The News Magazine for Hospitals

This issue 18,700

HOSPITAL TOPICS

LARGEST CIRCULATION IN THE FIELD

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KENNETH B. BABCOCK, M.D. (see page 5)

JUNE
1953

Meinecke Metal Medicine Glass Covers & Markers

Meinecke Colored Medicine Cards

Meinecke Medicine Tray Sets

THE MODERN ERRORLESS

MEDICINE TRAY TECHNIQUE

Thousands of hospitals have discovered that you simply don't make errors when you use the Meinecke colored marker card system of administration. The metal cover stays with the glass, the card with the cover, and the doctor's medication orders on the card. That means the colored card is your easy guide to when and what to administer. The system gives you a simple means of keeping records straight before and after medication.

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Ten colors available for modern, simplified hospital routine. Differently colored cards denote the different hours of administration. Thus, they simplify work and minimize errors.

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White— B.T.—9 P.M. (bedtime)

Blue — A.C.—7 A.M., 11:30 A.M., 4:30 P.M. (before meals)

Red — Q.I.D.—8 A.M., 12 noon, 4 P.M., 8 P.M. (four times a day)

Buff — P.C.—9 A.M., 1 P.M., 6 P.M. (after meals)

Pink — B.I.D.—10 A.M., 6 P.M. (twice a day)

Orange— Q. 3 HRS.—6 A.M., 9 A.M., 12 noon, 3 P.M., 6 P.M., 9 P.M. (every three hours)

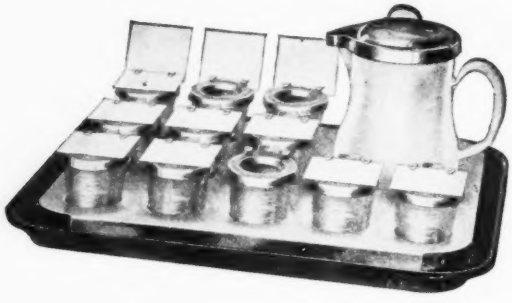
Grey — T.I.D.—10 A.M., 2 P.M., 6 P.M.

Purple — Round-the-clock medication

Salmon— Reserved for Special Cases

Either plain cards or cards printed as shown may be supplied. (Patents 1,020,896; 2,031,892; 2,095,817)

Card used in Vertical Position.



Medicine Glass Cover & Marker

Non-tarnishing, solid brass, heavily chrome-plated

A. *Cover and Pill Tray before card has been inserted.*

B. *Card used in vertical position (can also be attached flat.)*

Medicine Tray Set

Non-tarnishing, chrome-plated brass rack with matching light-weight plastic tray. 11 x 14 tray for 11 one oz. glasses and pitcher. 8 x 10 tray for eight one oz. glasses and pitcher. Tray sets for 12 and 20 glasses without pitcher also available.

Write for prices and descriptive literature.

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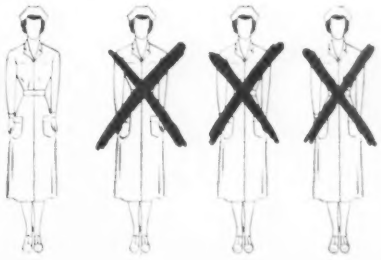
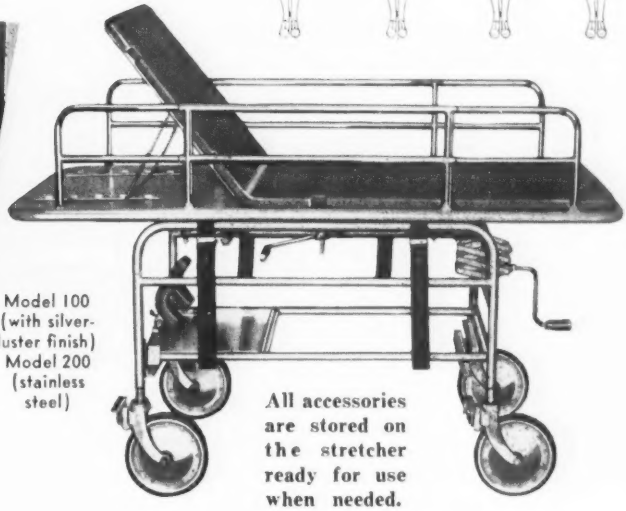


MOVES PATIENT OVER THE BED - -
With a simple turn of the crank the stretcher moves over the bed.



Model 100 (with silver-luster finish) Model 200 (stainless steel)

All accessories are stored on the stretcher ready for use when needed.

THEN TILTS TO TRANSFER POSITION
Just continue to turn the crank and the stretcher top tilts to the proper angle.

Just fifteen seconds . . . and even the smallest nurse or attendant can transfer the heaviest patient from wheel stretcher to bed if it is a Hausted "Easy Lift". This unit saves time and money for hospitals because one nurse does the job of many. The Hausted stretcher, available in Silver-Lustre and stainless steel, easily adjusts to the height of any hospital bed . . . it is 73½ inches long and 26½ inches wide. THE HAUSTED "EASY LIFT" STRETCHER IS IDEAL FOR USE IN POST-ANESTHESIA RECOVERY ROOMS AND IN "RECEIVING" AS AN EMERGENCY OPERATING TABLE.

TRANSFERS PATIENT WITHOUT EFFORT
When the stretcher top is tilted one nurse can quickly and easily transfer the patient from stretcher to bed.

Restraining Straps, Oxygen Tank Holder, and Fowler Attachment can be attached to most other make stretchers.

By turning the crank the "Easy Lift" can be easily adjusted to any desired Trendelenburg position.

HAUSTED Easy Lift WHEEL STRETCHERS

PAT. APPLIED FOR

HAUSTED MANUFACTURING COMPANY
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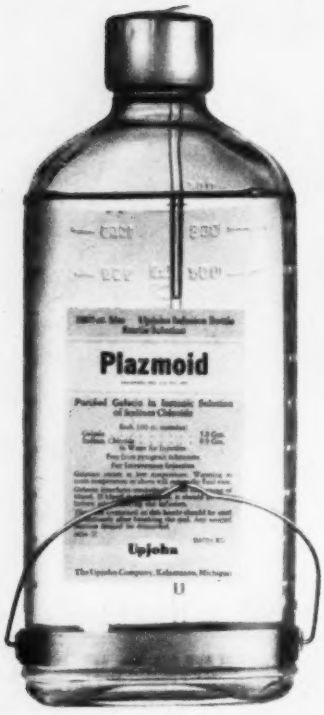
Upjohn



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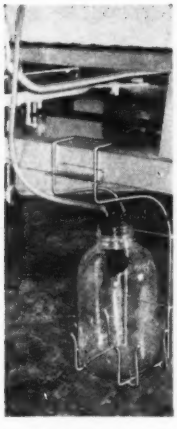

Bottle Holder keeps drainage bottle safe from accidents.

This efficient new vacuum pump has all the power necessary for mild drainage and aspiration, yet the power unit itself occupies only 2½ inches of space, and is offered at a fraction of the cost of conventional pumps. Dial control makes possible variable vacuum from 2 to 15 inches; air displacement up to 600 cubic centimeters per minute. Supplied complete with special float which fits ½- or 1-gallon Mason type jars. The unit is sealed in a black case mounted on machined aluminum base. Base mounted on sponge rubber feet — will not "crawl." An aluminum bracket is supplied to attach pump unit to bed rail. Unconditionally guaranteed for one year.

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In lots of 6, each 4.50
Per dozen 50.00

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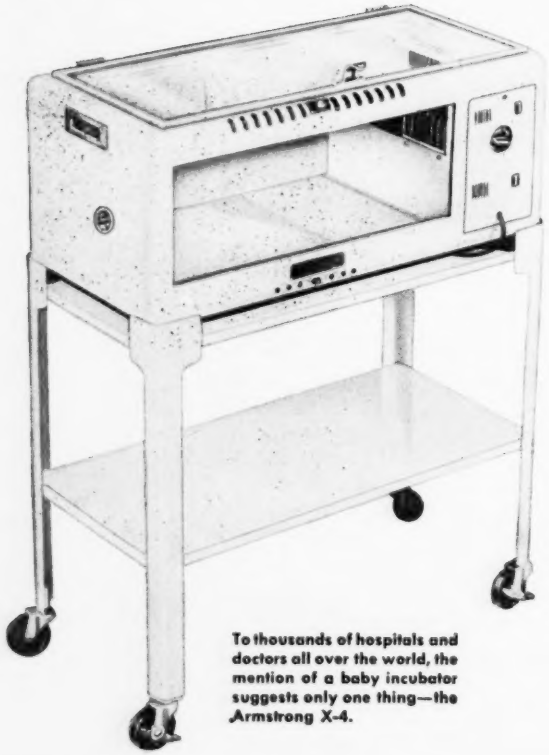

To thousands of hospitals and doctors all over the world, the mention of a baby incubator suggests only one thing—the Armstrong X-4.

● Ten years ago—but only after several years of experimental work and hospital testing—the first Armstrong X-4 Baby Incubator was sold to a hospital.

Since then, over 17,000 X-4 Baby Incubators have been delivered to hospitals in the U. S. A. and 67 foreign countries. This, we believe, spells EXPERIENCE. But there has never been one cent of the cost for this experience included in the price of the X-4.

Almost anyone could manufacture a baby incubator and perhaps even match the low price of the X-4. But no one can match the experience that goes free with every Armstrong Baby Incubator.

You never miss the troubles you don't have. But there's no reason for taking chances. If you want to be SAFE—if you want to be SURE—if you want EXPERIENCE—buy the Armstrong X-4 (Nursery type) Baby Incubator. It is backed by over 17,000 incubators' worth of experience—and is still sold at the same low price.

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"Back of every Armstrong X-4 Baby Incubator is over 17,000 incubators' worth of experience"

HOSPITAL TOPICS

The News Magazine for the Hospital Staff

JUNE, 1953

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PERSONALITY OF THE MONTH

● This issue of TOPICS which contains the report of the Tri-State Hospital Assembly* is the opportune time to honor Kenneth B. Babcock, M.D., Director, Grace Hospital, Detroit. It is appropriate because as president, Michigan Hospital Association, Dr. Babcock played an active role in seeing that convention activities ran smoothly and was in part responsible for the success the meeting attained.

Dr. Babcock applies the same enthusiasm and hard work displayed at Tri-State to the activities of other organizations of which he is a member, as well as to the functions of his own hospital. He holds membership in the ACHA and the Society of Medical Administrators. A Fellow of the American College of Surgeons, he is also president and trustee, Michigan Hospital Service; trustee of the Michigan Hospital Association and the Parkside Hospital. He is treasurer, board of trustees, Detroit Area Hospital Council, and is also on the board of directors, United Community Service and the Detroit Council on Community Nursing.

During World War II, Dr. Babcock served as commander of a field hospital. He ended his three and a half years of service with the rank of lieutenant colonel and was awarded the Bronze Star for meritorious service.

Dr. and Mrs. Babcock have four children. Two sons, following in their father's footsteps, are studying medicine. Dr. Babcock combines hobby and recreation in a good game of golf.

See page 31

Fig. 1. The wheel stretcher is placed alongside the operating table with the Davis Roller ready to use. Notice position of the draw sheet extending from under the patient and over the Roller. The nurse on the far side of table reaches across and with the draw sheet tilts the patient. Davis Roller is now placed about half way under the patient. Be sure to have patient's head and legs resting on the Rolier.

Fig. 2. Patient is in position on Roller and ready to move. The nurse on the stretcher side rolls up draw sheet and pulls. Nurse on far side lifts gently to stabilize patient. Notice patient's head is resting on the Roller.

Fig. 3. Patient has now traveled across the Davis Roller and is on the wheel stretcher. The action of the Davis Roller has carried him without lifting or twisting.

In hospital room—in surgery—in X-ray

MOVE PATIENTS

faster . . .
safer . . .
better . . . *with*

Davis

PATIENT ROLLER

A Gilbert Hyde Chick Product

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Fig. 4. The nurse on the stretcher side now reaches across the patient and with the draw sheet tilts the patient enough to permit removal of the Roller. Roller is removed and patient is on the stretcher and ready to be taken to recovery room or regular hospital room.

Fig. 5. Patient is now ready to leave the operating room. Transfer has been accomplished with no strain on personnel and with no strain on patient.

Fig. 7. Transfer from stretcher to X-ray table is just as smoothly accomplished. Davis Roller bridges gap between stretcher and table.

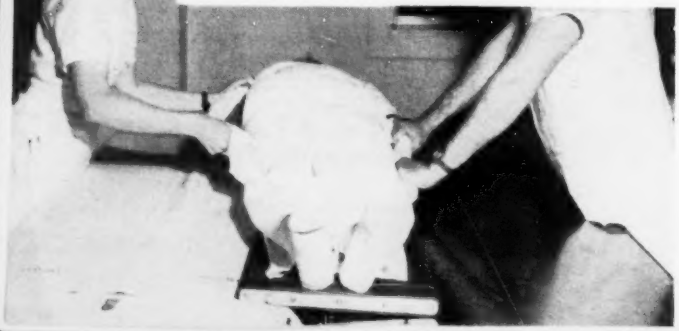


Fig. 6. Patient is now transferred from stretcher to bed in same manner as from operating table to stretcher.

Calendar of Meetings

JUNE

1- 5 American Medical Assn.
New York City

14-18 American Society of Medical Technologists
Brown Hotel, Louisville, Ky.

15-19 American Physical Therapy Assn.
Baker Hotel, Dallas, Tex.

15-19 Institute on Hospital Pharmacy
Loyola University, Los Angeles

16-19 Medical Library Assn.
Newhouse Hotel, Salt Lake City

22-26 National League for Nursing
Auditorium, Cleveland

22-26 Institute on Anesthesia
Somerset Hotel, Boston

22-26 Annual International Consumer Credit Conference, New Orleans

28-July 2 American Society of X-Ray Technicians
Royal York Hotel, Toronto, Ont.

AUGUST

14-21 International Congress on Mental Health, London

24-28 American College of Hospital Administrators, Sixth Western Institute
Stanford University, Palo Alto, Calif.

25-28 American Dietetic Assn.
Shrine Civic Auditorium, Los Angeles

29-30 American College of Hospital Administrators, 19th Annual Meeting
San Francisco

31-Sept. 3 AHA Convention
San Francisco

31-Sept. 6 World Medical Assn.
Amsterdam, Holland

SEPTEMBER

13-17 International College of Surgeons
Waldorf Astoria Hotel
New York City

30-Oct. 1 Washington Hospital Assn.
Olympic Hotel, Seattle

OCTOBER

5- 9 American Assn. of Medical Record Librarians
Palace Hotel, San Francisco

14-16 Mississippi Hospital Assn.
Buena Vista

18-21 American Osteopathic Hospital Assn.
Statler Hotel, Los Angeles

19-23 Institute on Purchasing
Penn Sheraton Hotel, Philadelphia

26-30 Institute on Dietary Department Administration, Park Sheraton Hotel, New York City

29-30 California Hospital Assn.
Mar Monte Hotel, Santa Barbara

NOVEMBER

2- 6 Institute on Supervisory Training
Edgewater Beach Hotel, Chicago

12-13 Nebraska Hospital Assn.
Hotel Cornhusker, Lincoln

16-20 Institute on Housekeeping
Somerset Hotel, Boston

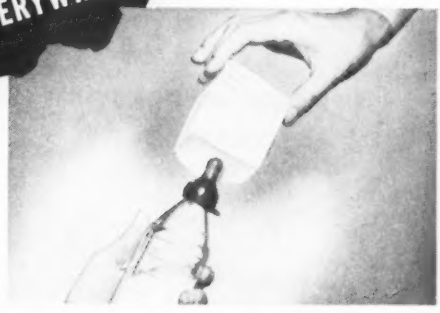
DECEMBER

1- 4 AMA Clinical Session
St. Louis

JANUARY 1954

26 Massachusetts Hospital Assn.
Hotel Statler, Boston

USED BY HOSPITALS EVERYWHERE



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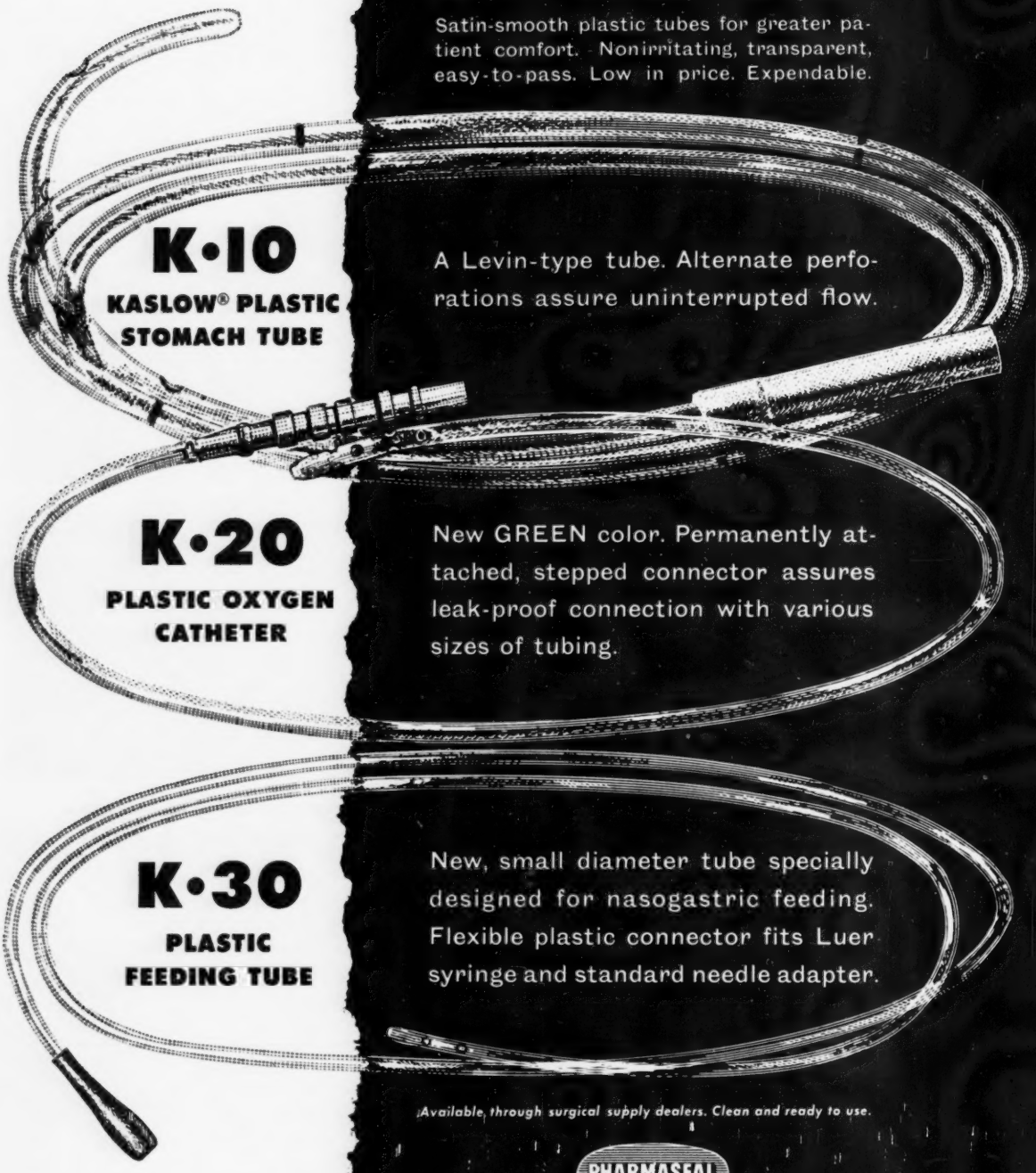

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Prevention of Bleeding

Synkayvite-C Lozenges 'Roche' are new, orange-flavored lozenges which provide vitamin C for promotion of wound healing and vitamin K for prevention of secondary hemorrhage following tonsillectomy.

These candy-like lozenges dissolve easily on the tongue. They are pleasant to take even when swallowing may be difficult following tonsillectomy.

Synkayvite-C Lozenges are available for prescription use in bottles of 20, 100, and 500.

A Help in Reducing

Melozets, a new "graham-cracker" methylcellulose wafer for the aid of dieters, is announced by Sharp & Dohme, Inc.

Melozets look and taste like graham crackers. When taken with water, the methylcellulose, a hydrophilic colloid, swells up — increasing the bulk and giving the patient a satisfying feeling of fullness. This bulk substance has very little caloric value—30 calories per wafer—and can be used to relieve the gnawing hunger which results from a reduced calorie diet. Thus, the patient is encouraged to adhere to his diet requirements.

Overweight in an overwhelming number of cases is due simply to overeating. A patient, however, who has become accustomed to a large intake of food frequently has difficulty in cutting down quantity because of the resulting pangs of hunger.

The obese patient builds up his extreme intake of calories by his frequent nibbling, his "second breakfast" and "afternoon snack." Melozets are the substitute which will satisfy this between-meal craving. Furthermore, they can be prescribed as an adjunct to any therapeutic regime. Methylcellulose passes through the gastrointestinal tract in a physiologic manner without interference with normal digestion and absorption. Tests have shown evidence of no toxic manifestations.

Each pleasant-tasting wafer contains 1.5 Gm. of methylcellulose and approximately 70 mg. of sodium.

One or two Melozets followed by a full glass of water may be taken one-half hour before meals or to relieve hunger between meals. Not more than eight wafers should be taken in a 24-hour period. They should not be used in the presence of intestinal obstruction.

Melozets are supplied in ½ pound boxes (approximately 25 wafers).

New Penicillin Compound

A new injectable penicillin combining the antibacterial properties of three separate forms of the antibiotic, has been developed by Wyeth.

Bicillin All-Purpose, the new compound, is a combination of benzethacil (Bicillin, Wyeth), procaine penicillin, and potassium penicillin, the three salts having varying degrees of potency and longevity.

The new compound provides a means of quickly obtaining high penicillin blood concentrations for quick action against severe infections, yet maintains effective levels for over a week.

Bicillin All-Purpose is supplied in single dose vials in dry powder form for pre-injection reconstitution. It is stable three years or more before reconstitution, and a week afterward if refrigerated. Prepared dose is 2 cc. in volume.

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Compare the killing time of this superior bactericidal agent		
Vegetative Bacteria	50% Dried Blood	Without Blood
Staph. aureus	15 min.	2 min.
E. coli	15 min.	3 min.
Strept. hemolyticus	15 min.	15 sec.

PRICE
Per Gallon $5.00
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clinical notes

Premature Delivery

The conduct of premature delivery is becoming increasingly important as a factor in decreasing neonatal mortality. Writing in the *Mississippi Doctor*, April, 1953, O'Neal gives some sound advice in the care of such cases.

Delivery is usually by the vaginal route, but section must be considered in placenta previa, abruption placenta, pre-eclampsia and certain Rh-sensitized patients.

Spontaneous delivery is usually safer near term, but this is not necessarily the case during premature labor. Drugs which interfere with respiration are to be avoided. If there is considerable apprehension, demerol may be given. Oxygen should be administered if there is cardiac decompensation, if labor is precipitous or if the fetal heart becomes irregular, and is continued throughout anesthesia.

An episiotomy is done routinely to spare the fragile fetal head. Vitamin K administration to mother and fetus is also recommended. Anesthesia is of the conduction type, either caudal, saddle, or pudendal block.

With complete dilatation and the head on the perineiu, the patient is draped, and given 100 percent oxygen. Use of forceps is optional. Mucus is aspirated as soon as the head is delivered, and the cord is not clamped until pulsations have ceased. A prewarmed incubator is in readiness for the baby. Oxygen is given by nasal mask if indicated.

Control of Infections in Elderly Diabetics

Diabetic infections can be controlled with terramycin, according to a report by Walker in *The Lancet*. The author treated 70 diabetes patients with various types of infections. Therapy with terramycin was found to reduce the need for amputation, relieve pain, and eliminate a wide variety of infecting organisms from ulcers of the hands, feet, respiratory tract, and urinary tract in the series.

Toxicity appeared to be low in this study, and vomiting and diarrhea uncommon. Hence there is little risk of disturbing the diabetic control, and no change of diet is required.

In 50 cases of infections of the feet, Walker reported that the antibiotic produced excellent or good results in 46 cases. Swelling and pain subsided rapidly, with conspicuous improvement in 48 hours. Of these patients, 43 were over 60 years of age and all but one over 50.

Development of resistance of the microorganisms to the antibiotic was not observed, the author states, though several courses of therapy were administered in a number of cases. Because of continuing hypertension in elderly diabetics, their infections are likely to occur again and again.

Hypothyroidism in Children's Allergy

Congenitally hypothyroid fetus may be maintained by the mother's thyroid substance, which in this country is usually normal in amount and sufficient to develop a normal fetus throughout pregnancy, according to Reilly of San Francisco, in *Annals of Allergy*, March-April, 1953.

The acquired thyroid substance from the mother may not be used up for several weeks or months after birth, so that the usual signs of the deficiency will not be manifested until then. If the baby nurses, the mother's thyroid substance is also obtained thereby. Some of our so-called cases of acquired hypothyroidism are therefore probably congenital deficiencies.

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$1,000* A YEAR

*actual figure based on average 200 bed hospital's annual expenditure for syringe service.

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The concurrent use of CORTONE and physiotherapy makes it possible to increase range of motion and muscle power, to relieve pain, and thus to rehabilitate severely handicapped patients.

Snow, W. B., and Coss, J. A., N. Y. State J. Med. 52: 319, Feb. 1, 1952

CORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone.*

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News Letter

• House Appropriations Committee, in cutting Hill-Burton funds for fiscal year 1954 to new low of $50 million, criticized program's operation, recommended that Hill-Burton not be extended beyond 1955 until Congressional survey of its record is begun. House-approved figure is $10 million below the President's recommendation, $25 million less than the current year's appropriation. Senator Hill says he intends to fight for present $75 million, to avoid hardships which would be caused to incompleted hospitals in about 15 states if funds were cut off. AHA and ADA were scheduled to go before Senate Appropriations Committee to request more money for Hill-Burton and dental research.

• Hospitals' present exemption from collective bargaining obligations will be terminated if proposed amendment to Taft-Hartley Act is approved. American Nurses Association is behind amendment, introduced by Democratic Senators James E. Murray (Mont.) and Paul Douglas (Ill.). ANA is now at disadvantage because it has voluntarily surrendered right to strike, but cannot legally force employers to bargain on wages and hours.

• Commissioning of osteopathic physicians by armed services on same basis as M.D.'s and dentists is proposed in HR 5017, introduced in House by Rep. Dewey Short (R., Mo.), chairman, House Armed Services Committee. American Osteopathic Association had hoped to have long-sought authorization incorporated in pending doctor-draft bill, but committee members decided to keep issues separate.

• Extension of doctor-draft law for two more years was passed by House without serious opposition from floor. Priority II ceiling was lowered from 21 months (in present law) to 17 months. Senate opened hearings on bill May 18.

• New director general, World Health Organization, is Brazilian M.G. Candau, M.D., whose accession was announced by Washington regional headquarters. Working budget of $8,497,700 has been approved by program and budget committee, Sixth World Health Assembly, with final action on funds to be taken in plenary session of assembly.

• Elimination of $2,500 ceiling for individual taxpayer's deductions on medical expenses is purpose of HR 4981. Deduction of all expenses over two percent of gross income would be permitted under terms of HR 5022.

• American Medical Association holds its 102nd annual meeting in New York City, June 1-5. See July TOPICS for convention report.

Gordon H. Hamilton

IN BRIEF:

Current, important literature

"HOSPITAL SERVICE IN THE UNITED STATES"—Council on Medical Education and Hospitals, AMA, Journal of the AMA, May 9, 1953, p. 143. Report for 1952 includes: statistical material, such as bed capacity, average length of stay, bed occupancy rates; information on nursing personnel and schools; data on special services; survey of motion picture facilities in hospitals; data on technical personnel; analysis of hospitals using Standard Nomenclature; information on general practice sections; report on approved technical schools. Good reference material for hospitals.

"THE PHENOMENON OF ACCIDENT PRONENESS"—A. G. Arbous and J. E. Kerrich, Industrial Medicine and Surgery, April, 1953, p. 141. Fallacy of original concept of accident proneness is pointed out. Removal of presumably "accident-prone" individuals from group does not necessarily result in decrease in accidents. There is need for new approach aimed at reducing accident incidence by enhancing knowledge of mechanisms at work causing individuals to have accidents. Changing concept recognizes great variety of individual differences.

"HOW TO BUILD A STAFF"—J. O. Cromwell, M.D., Nursing World, March, 1953, p. 15. Clear statement of hospital's function in community is essential for building staff and keeping staff members interested. In addition to listing steps in building general hospital staff, author tells additional staff needed in psychiatric hospital.

"THE LEGAL AND MORAL ASPECTS OF UNNECESSARY SURGERY" — Charles U. Letourneau, M.D., Hospitals, May, 1953, p. 82. What is unnecessary surgery? Damage has been done to public confidence in doctors and hospitals because of careless use of term by some persons. There is no evidence of criminal intent on part of medical profession. However, hospitals and doctors do have responsibility of reducing to minimum the number of cases in which normal tissue is removed. Best hospitals provide for tissue committees.

"THE PROBLEM OF EXPERIMENTATION ON HUMAN BEINGS"—M. B. Shimkin, O. E. Guttentag, A. M. Kidd, and W. H. Johnson, Science, February 27, 1953, p. 205. Symposium includes discussion of problem from research worker's and physician's point of view, and analysis of limits of rights of person to consent to experimentation on himself and civil rights of military personnel in experimental procedures.

"MEDICOLEGAL ASPECTS OF BLOOD TRANSFUSION"—Committee on Medicolegal Problems, AMA, Journal of the AMA, April 18, 1953, p. 1435. Blood transfusion is as important a cause of death as appendicitis or anesthesia. Physicians and hospitals must take every precaution to safeguard patient against danger of transfusion complications. Sections of report include: hemolytic transfusion reactions, transmission of disease, other accidents following transfusion, protection of blood donor, preparation of blood diagnostic serums, qualifications of transfusionists.

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TOPICS reports on . . .

Association of Western Hospitals

TOPICS' photographs by G. M. Marshall

● The Association of Western Hospitals attained a peak in attendance and interest at its recent annual convention. Hospital people from nine western states, the territories of Hawaii and Alaska, and the Province of British Columbia attended the three-day meeting. Here is a TOPICS' report of the meeting.

Hospitals—Blue Cross—the Road Ahead

Harold Baumgarten, Jr., Manager, Hospital Relations Division, Blue Cross Commission, Chicago—The organic relationship between Blue Cross and hospitals imposes a dual responsibility on Blue Cross which must be ever recognized by Blue Cross administrative personnel as well as by hospital administrators. The first is the responsibility of making Blue Cross available to all persons. The second is to provide adequately for the needs of those who belong to Blue Cross.

This second responsibility is of great importance in the survival of the plan and is essentially the foundation of the road ahead.

The sick person wants and needs the results of hospital care—not the means to purchase it. The plan is designed to extend this care to him on a basis related to his needs—not on a dollar basis. Service benefits mean use of service as needed—not up to the dollar amount. If the public is to be benefited financially as well as therapeutically, a service benefit is imperative. As Blue Cross accepts the responsibility of service benefits, hospital administrators must accept the responsibility of protecting Blue Cross from over-use. Extra service, extended stays, excessive medications, unnecessary laboratory tests, and unnecessary admissions do exist and can be stopped. These mean more money to the hospital now, but in the long run it may be a lost subscriber to Blue Cross, who if financially unable to meet a monthly premium, cannot afford to pay a hospital bill.

The basic strength of Blue Cross lies in service benefits, possible because of hospital sponsorship to the program. Administrators are in a position to make service benefits a reality by cooperation with Blue Cross plans. Failure to understand each other's problems underlies every Blue Cross-hospital spat that exists today.

The public is determined to prepay cost of illness. If they cannot reach this goal through existing agencies, they will ask the government to do it even though they may recognize that the latter is a less perfect way.

I urge you to be responsible to the demand of society for a vehicle of prepayment. Work with Blue Cross for a return to the original concept. Blue Cross plans should demonstrate a sympathetic understanding of hospital needs, and conversely hospitals should recognize the many problems which confront Blue Cross in subscriber relations and competitive situations.

Manpower Reduction Through Modern Efficiency

Erros T. Copsey, Executive Housekeeper, St. Francis Memorial Hospital, San Francisco—Many executive housekeepers have taken positions in hospitals where a reduction in the staff and modernization of the department were badly needed. When I came to St. Francis Hospital in 1946 there was a staff of 70 in housekeeping with 16 wall washers under another department. I had come from a small hospital and though at first I thought this staff necessary, I soon discovered the staff could be reduced by setting up efficiency methods.

The first thing to be done was to organize, train, and then supervise employees with the least waste of manpower and materials. To organize meant to reduce the staff. Today, there are 54 employees working a 40-hour week. Each has been trained in the proper methods and proper procedures to do the work. New equipment and new supplies have been furnished. If the worker has learned to work efficiently, there will never be any time lost. To see that the work is being done, the housekeeper must be alert as to what each and every one employed is doing. The housekeeper can get eight hours of work out of each employee if she sees that there is proper supervision.

Personnel Credit Union

Helen Jones, Community Relations Director, St. Francis Memorial Hospital, San Francisco—In view of the phenomenal success of credit-unions in other businesses and in other hospitals, we felt it must have some value in helping employees and that by helping employees we, as an employing organization, could be helping ourselves. The reflection of good will to employees from better service by employees is becoming increasingly more recognized.

We started our credit union four months ago as part

(Continued on page 18)

Above: Helen Jones, community relations director, St. Francis Memorial Hospital, San Francisco, talks to session about personnel credit unions.

WESTERN HOSPITAL ASSOC

1—Bill Flint, Cutter Labs., Frank Schmidt, supt., Franklin Hospital, San Francisco, and Dean Conley, exec. director, ACHA, Chicago.

2—E. M. Carpenter, adm., Fairmont Hospital, San Leandro, Calif., Mrs. Carpenter, and daughter Ann.

3—John L. Sundberg, adm., Caldwell (Id.) Memorial Hospital; Werner W. Hendrickson, asst. adm., and Laverne Plummer, buyer, Emanuel Hospital, Portland, Ore.

4—Outgoing president Wonnacott at opening session.

5—This group included: Dr. Price, Honolulu; Mrs. Orville Booth; Mel Scheflin, exec. sec., Assn. of Western Hospitals, San Francisco, and Bill Little, Becton Dickinson.

6—From Holy Cross Hospital, Salt Lake City, were: Beverley Ewles, R.N.; Karma Barrett, R.N.; Laura Martin, R.N.; Sister John of the Cross; Sister Laurencita, asst. adm.; Jan Mathews, R.N., and Mrs. Lucille Morris, O.R.S.

7—James Hamilton, U. of Minn., addresses session.

8—Raymond F. Farwell, Virginia Mason Hospital, Seattle; Vesta Dow, adm., and Marian Irwin, R.N., nursing supervisor, Puget Sound Naval Memorial Hospital, Bremerton, Wash.; John Darmer, Sonoma State Home, Eldridge, Calif.

...IATION RECORD ROUNDUP

9—M. J. Bradbury, adm.; Mary Bradbury, supt. of nurses; Mary O'Neill, M.D., and Frank O'Neill, M.D., co-partners, all of Highland Hospital, Auburn, Calif.

10—John Cline, M.D., San Francisco, past president, AMA.

11—John Matthay, president, Matthay Hospital Supply; Walter Oliver, Becton Dickinson; Arthuretta Walter, R.N., adm., Craig (Colo.) Memorial Hospital; Bob Henwood, adm., Palm Springs (Calif.) Hospital; Mrs. Elsie Mercer, R.N., adm., Washington Minor Hospital, Tacoma, Wash., and Bill Little.

12—Virgil F. Bradfield, adm., Stanislaus County Hospital, Modesto, Calif.; Ralph J. Hromadka, supt., Santa Monica (Calif.) Hospital, and John L. Moriarty, adm., Children's Hospital, Honolulu.

13—Dr. Price, Honolulu; Bill Little; Mrs. Booth; guest; President Orville Booth; Bob Henwood; Max Gerfen, adm., Sequoia Hospital, Redwood City, Calif., and Norman L. Thompson.

14—Frank Lloyd Wright, architect (second from l.), is greeted by Mayor Earl J. Glade, Salt Lake City. L.: Mel Scheflin.

15—Mrs. Russell N. Tucker places lei around neck of past president at exhibitors' Hi-Jinks party.

16—Frank J. Walter, adm., Good Samaritan Hospital, Portland, Ore.; John Cline, M.D., Rear Adm. Sterling S. Cook, M.D., Norfolk, Va.; George Wood, Peralta Hospital, Oakland.

17—James Hamilton, hospital administration, Univ. of Minn.; Orville Booth; John Cline, M.D.

18—John A. Dare, adm., Virginia Mason Hospital, Seattle, Wash., and Mrs. Dare.

Above: Frank Lloyd Wright (l.) is shown with Mayor Earl J. Glade of Salt Lake City. The famous architect spoke on "Hospitals of the Future" before a general session of the convention.

of our personnel relations program. The first step in publicizing the union was in the direction of educating employees by means of a bulletin inserted in everyone's paycheck. Employees then were asked to attend a general meeting for election of 11 employee officers of the credit union. After the election the credit union was again publicized and "plugged" to the limit. In the short time that the credit union has been in function, 108 members have enrolled out of a potential of 500.

Since hospitals are staffed by a more diversified group of people than are found in many other institutions, it is obviously more difficult to present to them the principles and purposes for which their management is working. To this end, all phases of a general public relations program in a hospital are important.

Since our administrator wants the employees to feel they are working with him to achieve the goals of St. Francis, he knows they must feel closer to the over-all organization and not to isolated groups. Besides our house organ and our employee conference, we feel that our credit union is another vital step in the direction of unity of effort within the hospital.

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Hospitals of Tomorrow

Frank Lloyd Wright, Architect, Phoenix, Ariz.—I believe in the healing virtue of beauty. The hospital of tomorrow should be located outside of the metropolitan area where it is quiet and where the patient can view green foliage and growing things.

Hospitals are too large and not solvent. There should be three small hospitals in place of one large one—so that hospital personnel can get acquainted with the patient and his family.

Today there is too much standarization in hospital design. Hospitals should be built for patients and not for the doctors.

Future Medical Changes Will Affect Hospitals

John W. Cline, M.D., Past-President, AMA, San Francisco—There is no limit to the possible growth of medicine and keeping people alive longer will change hospital treatment. Laboratory tests have already increased, the x-ray department has developed, cyctoscopy—20 years ago a rarity—now is in use in virtually every hospital. Unless something better comes along soon, cobalt bombs will become routine.

There is more confidence in today's hospitals. Medical advances have cut the patient's stay to 6.5 days. Cost per day of hospital care is increasing but actual cost for illness has increased very little because of early ambulation of patients.

Young, well-trained men, gravitating to smaller communities have helped promote use of small hospitals. This trend will continue because of the desire of the patient to be near home. Even traffic congestion in cities is a factor in keeping patients and doctors in their home towns.

An increase in hospital insurance seems to be the answer for illness costs. More than 90 million persons now carry prepayment policies. Hospitals, however, should watch out for plans which tend to dictate the hospital and medical care and economic aspects of hospital administration.

Medical Service Audit for Community Hospitals

John L. Sundberg, Administrator, Caldwell (Idaho) Memorial Hospital—An impartial, outside qualified individual should make the medical audit. Members of the medical staff may object to use of records by outside authority, but the American College of Surgeons holds that records belong to hospitals, so this practice is permissible.

The outside expert studies the record of each patient from admission to discharge and tabulates percentages of correct diagnosis, thus revealing the weak and strong members of the staff. His report is submitted to the administrator who turns it over to the board of trustees. A code system is used so that only the administrator knows the identity of the doctors in regard to the records.

An interpretation of the report is given the trustees by the chief of staff. If doctors are out of line, conferences may be held, or if necessary, surgical privileges should be withdrawn.

Disadvantages of a medical audit are: that a record may be subpoenaed as evidence in a malpractice suit; that no one auditor has knowledge of all types of cases, and that if not kept confidential, it might be used to damage a physician's reputation.

Advantages of the audit are: it saves the record committee's time; saves the doctor time and relieves him of the responsibility of diagnosis of other doctors; it increases the quality of patient care, and keeps the medical staff on its toes.

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Scanning the News

Mechanical Appliances Aid Heart Surgery

Devices now being developed to aid the surgeon in making repairs on the heart were described at the recent annual meeting of the American Heart Association. Among these appliances were:

A plastic "well," a blood storage chamber which is sewed to the heart and permits surgeons to work inside the heart for as long as two hours without having the patient's blood pressure drop to a dangerously low level.

Bottle-shaped, artificial valves which have aided in operations to correct leakage between heart chambers.

A three-bladed knife used on the valve which controls the blood flow of the great aorta.

A robot heart to keep the patient's heart empty while surgery is being performed.

Whale Food Suggested to Prevent Allergy

Mothers may soon be shopping for whale food for their infants.

A one-ton whale heart is going to be processed into a new kind of protective baby food which it is hoped will keep babies from developing allergies to more common foods, such as beef and eggs.

The whale product will be given first to experimental animals and then will be canned as food for infants suspected of having inherited an allergic weakness.

Since it is believed that babies of allergic patients become sensitized to the first foods that enter their digestive tracts after birth, allergists are going on the theory that it would be better for the infants to be allergic to whale meat than to more ordinary dietary items.

Lung Cancer Leading Killer in Male Respiratory Ailments

Lung cancer heads the list of diseases of the respiratory tract as a cause of death among white males in the United States, the Metropolitan Life Insurance Company reported recently.

The death rate for respiratory cancer among the company's industrial policyholders was 25.7 per 100,000 in 1950-51. The rate for respiratory tuberculosis was 21.9 per 100,000, and that for pneumonia, 14.6.

Twenty years ago, the lung cancer death rate for men 65 to 74 was less than one-third the tuberculosis rate. Today's rate in that age group is nearly double the tuberculosis rate.

Hope for Collectors: 30-Year Bill Paid

Thirty years after his wife's hospitalization, Simeon A. O'Rear walked into the Union Hospital, West Frankfort, Ill., to pay the hospital bill.

Explaining that he hadn't had the money for the bill in 1923 "because of a five-month strike," Mr. O'Rear handed over $150 to the hospital's manager, R. Somers. Mr. Somers said the hospital had no record of the debt.

Mr. and Mrs. O'Rear, who now reside in Jasper, Ala., live on a $96.75 monthly pension which he receives as a veteran of the Spanish-American war.

Thyroid Glands Transplanted from Baby, Guinea Pig

Two history-making thyroid transplant operations have been performed by surgeons in Philadelphia and New Orleans.

(Continued on page 22)

The first officers of the newly organized chapter of the American Association of Hospital Accountants, the first to be organized in the West, received its charter recently. From l. to r.: Frances B. Ducey, national board member and chief accountant, French Hospital, San Francisco, who is making the charter presentation; Lucy Gorton (treasurer), chief accountant, East Oakland Hospital, Oakland; Charles Cullen (a director), administrative officer, U.S. Public Health Hospital, San Francisco; Elmer O. Massmann (vice-president), administrator, French Hospital; Gardner E. Burke (secretary), business manager, Sonoma County Hospital, Santa Rosa, and Alfred E. Maffly (president), administrator, Herrick Memorial, Berkeley. New members will be welcomed by the organization.

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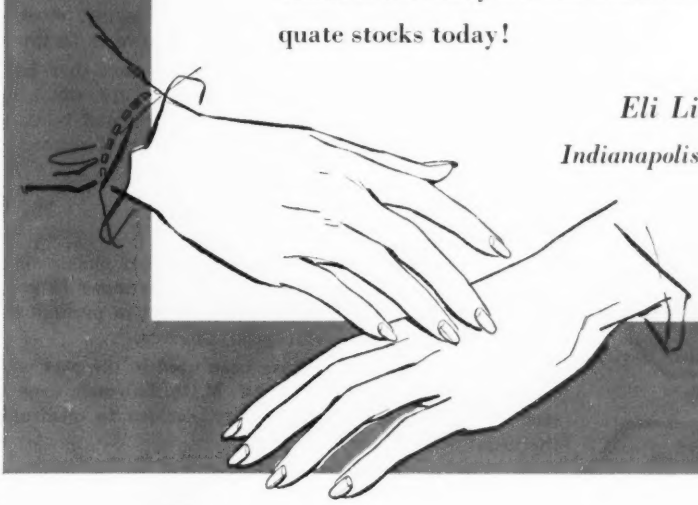

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The cream for a dry dermatitis resulting from contact with drugs, chemicals, paints, plastics, or clothing and from insect bites or severe sunburn. A fragrant, greaseless, pleasant-to-use vanishing cream.

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In the first successful transplantation of an entire thyroid gland from one human being to another, at the Einstein Medical Center, Philadelphia, a 29-year-old woman was given the gland of a three-week-old baby. The woman's thyroid and parathyroid glands had been removed 10 years earlier. The baby from whom the gland was taken was born with a hopeless malformation, and the parents agreed to permit the transplantation.

Thyroid and parathyroid glands of an embryo guinea pig were transplanted into the stomach muscles of a New Orleans woman, in the second unusual operation. It is hoped that the glands will remain alive there and pour thyroid hormones into the bloodstream.

Whether the animal glands are working is not yet known, because the woman has not returned to the hospital for follow-up studies. The operation was performed three months ago, after the woman's own thyroid and parathyroids were removed because of cancer.

Chemicals May Increase Power of Some Drugs

Two new chemicals have shown promise in preliminary experiments in multiplying the effects of certain drugs without increasing their toxic effects.

One chemical, SKF 525A, developed by Smith, Kline and French Laboratories, Philadelphia, is said to have prolonged the action of a group of pain-relieving, muscle-relaxing, and sleep-producing drugs from five to 10 times.

Abbott Laboratories scientists revealed that they have developed a chemical with similar action, P-19, which increased the effectiveness of some sedatives and relaxing drugs and greatly prolonged their duration of action.

Large Doses of Progesterone May Prevent Miscarriage

Injection of progesterone in large doses may enable some women who would otherwise have miscarriages to complete their pregnancies, it has been found in preliminary studies at Michael Reese Hospital, Chicago.

Progesterone injections have been used in the past with little benefit, but Arthur K. Koff, M.D., chairman, department of obstetrics and gynecology, decided to quadruple the usual dosage.

Of 27 women who received the large doses, eight carried through their pregnancy and delivered normal babies. With conventional treatment, only one in 27 could have been expected to carry a child to delivery. Michael Reese physicians pointed out that the group studied was too small to warrant any definite conclusions.

Human Patients to Benefit from Largest X-Ray

The largest x-ray in the western world may be used in treating human patients by the end of this year, University of California scientists have announced.

The 70,000,000-volt synchroton, which was assembled in San Francisco in 1951 and was accepted by the University last fall, has been used in animal research to some extent.

University radiologists say that the machine probably will make possible the concentration of higher doses of radiation on deep-seated tumors, with less dosage to the healthy tissue outside the tumor region.

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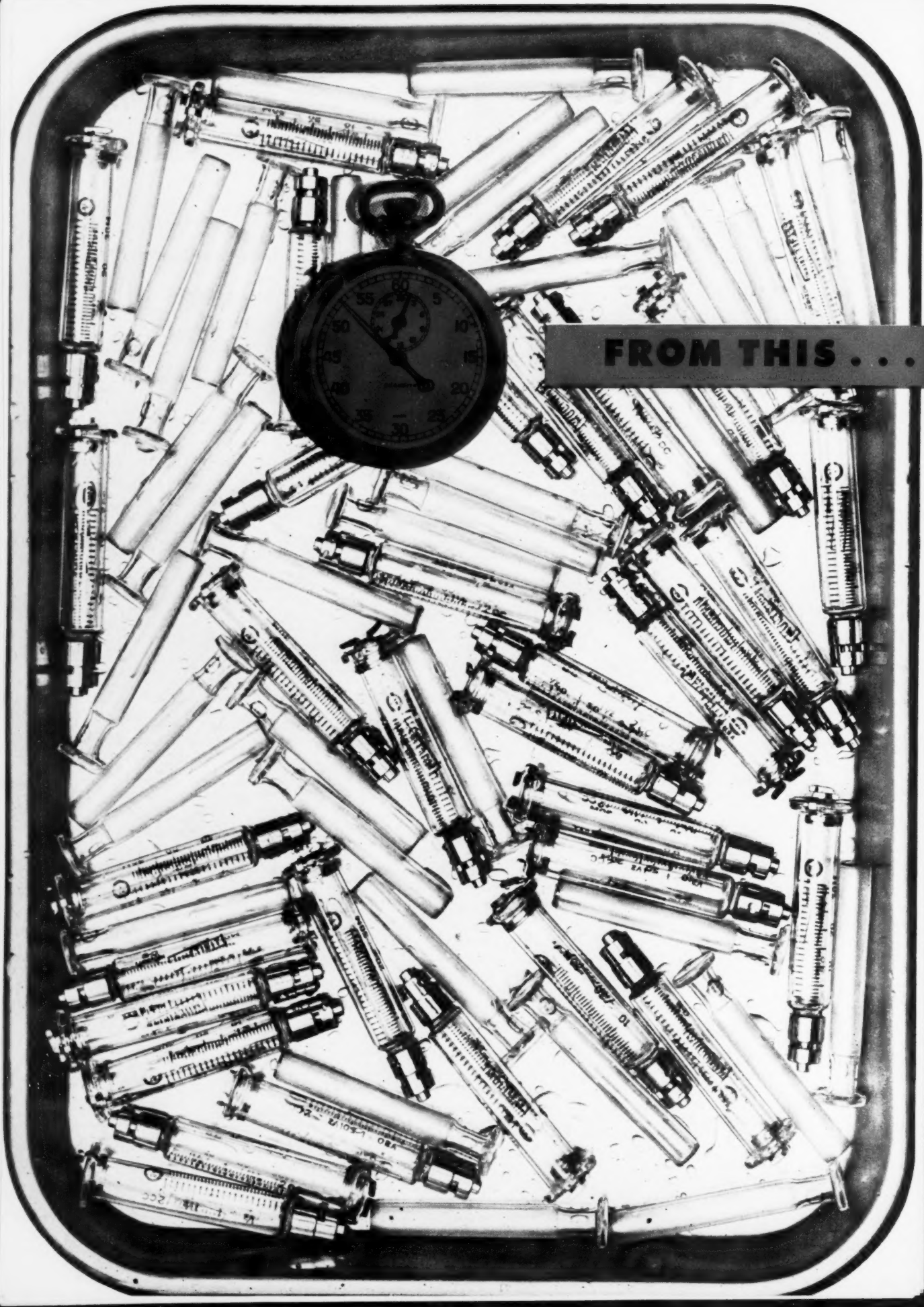
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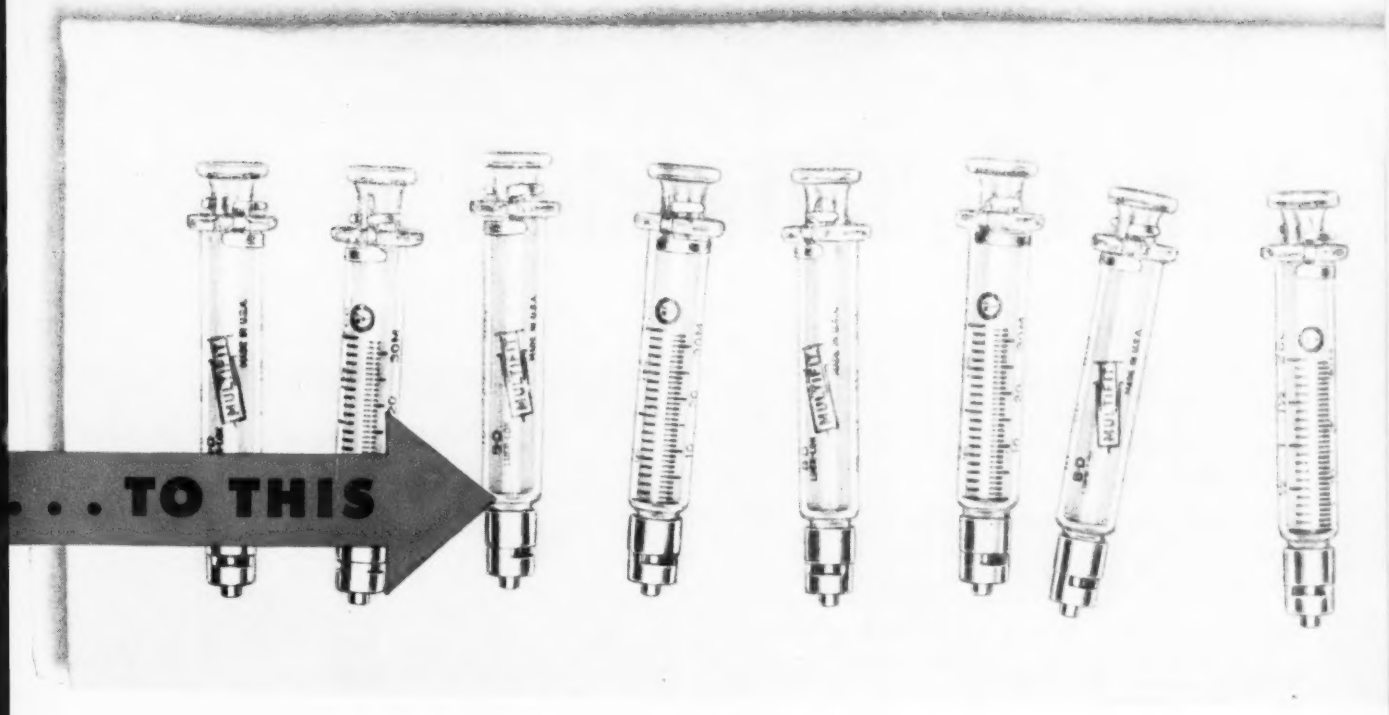

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New High Reached at Upper

● Total registration at the sixth annual Upper Midwest Hospital Conference, held in Minneapolis May 13-15, was approximately 3,500—an increase of almost 350 over last year. Abstracts of some of the papers presented appear in this report.

Significant Trends in Hospital Care

James Hamilton, Professor and Director, Hospital Administration, University of Minnesota, Minneapolis—There is need for a dynamic, forward-looking concept of the place and function of hospital service in our society.

In studying current trends, we have divided them into trends associated with medical service and practice and trends in social, economic, and physical fields.

A significant trend in medical service and practice is that toward greater emphasis on disease prevention. In research as well as in practice, there is more emphasis on the diseases which now are the leading causes of death, such as cancer and heart disease. Along with additional stress on prevention, there undoubtedly will have to be more emphasis upon health education. We can expect that the largest portion of hospital operation effort will be spent upon ambulatory care.

Increasing specialization in medical care and increasing dependence on mechanical devices and technical procedures are other important trends. With more specialization will come an increase in group practice. Doctors will tend to center their practice in one hospital, because of the need for closer teamwork with other physicians, and for more consultations. However, along with more specialization will come increasing recognition of the value of the general practitioner—as a coordinator of specialists.

With further development of mechanical devices and technical procedures, I can see a great development of laboratory activity, and increased need for the centralization of laboratory and treatment facilities within the community.

In the social, economic, and physical fields, we have these trends:

(1) Recognition that we are in the midst of an expanding era of health service to the people. Costs will continue to increase, not just because of inflation, but because of greater influence of doctors and because of advancements in medical science. The consumer will devote more of his income to hospital care—will tend to seek "services" rather than "materials."

(2) Extension of third-party payments, with the result that there will be a smaller number of actual purchases of hospital and medical care. A complicating factor is the increasing influence of lay people who have taken a special interest in certain diseases, such as tuberculosis, cerebral palsy, and heart disease. These groups, seeking special attention for the problems in which they are interested, may become impatient and may even decide they would prefer government purchasing to the voluntary group. To help strengthen our arguments for the voluntary method, we need to eliminate competition and fighting for prestige within the professions.

Above: James Hamilton (second from l.), director, University of Minnesota's hospital administration course, donned the oversized tie to get into the spirit of the conference's traditional "Paul Bunyan Night." With him are Mrs. Hamilton (l.), Mrs. L. C. Pittelkow, and L. C. Pittelkow, Physicians and Hospital Supply Co., Minneapolis.

(3) Centralization of care, with a growth of medical centers in cities, to avoid duplication of facilities and services.

(4) Changes in building, planning, and construction, to provide for altered needs. There will be less space for surgery, more for laboratories, dietary, mobile units of laboratory equipment, home care equipment, and service facilities.

(5) Movement toward greater external control and new agencies of control.

(6) Recognition of need for higher degree of administrative skills and emphasis on education to secure these skills. Principles used in industry can be taught and understood, but they cannot be applied to hospital operation without being modified considerably.

Is Two-Year Nursing Course Possible?

Mildred L. Montag, R.N., Ph.D., Associate Professor of Nursing Education, Teachers College, Columbia University, New York City—In conducting our research program on a two-year nursing course, one necessary assumption is that it is possible to divide nursing into three categories: one which includes very simple functions, one which includes very complex functions, and a third which lies in between those two and includes the technical-type functions which compose the bulk of nursing.

The purpose of our project—financed by an anonymous grant of $100,000—is to determine whether it is possible to develop a program which will prepare students in junior

Midwest Hospital Conference

college for the technical-type nursing functions. We chose junior colleges for our study because they are the fastest-growing institutions in the country, and because it is in these schools that semi-professional workers in other occupations, such as stenography, are prepared.

Two schools are now cooperating, and two more will be added in the fall. Before a school is selected, the college must show willingness to assume complete control of the program. There must be adequate facilities, and hospitals and other community agencies must be willing to provide learning experiences. The community must be ready to accept the program. Cost must not be prohibitive. Graduates must be eligible to take an examination for licensure in the state in which the school is located.

The faculty will be appointed by the college and paid by the college. Only nursing faculty employed will be

Below: Filling their plates at the buffet supper on "Paul Bunyan Night" were (l. to r.): Mrs. Ruth Holland, R.N., and Mrs. Evelyn Annand, R.N., nursing service, St. Luke's Hospital, Duluth; Ed Guentz and Henry W. Beck, Ohio Chemical and Surgical Equipment Co.

those who teach nursing courses. Each individual school will set up its own program, but all schools will cooperate in planning curricula. The average curriculum will include about one-third general and two-thirds technical education. Students will take the same courses in general education as other college students.

At present we don't know how much time in the training program is devoted to activities required by nursing service and not by nursing education. We hope to provide meaningful learning experiences without repetition. I think perhaps too much repetition has deferred learning instead of promoting it.

The student will be a student throughout, not a worker on the hospital staff. However, we still expect the student to learn by doing—but as a learner, not a worker.

The curriculum of one pilot school includes in the first year: a one-year course in communication skills; a one-year course in the survey of science, including human biology the first semester and chemistry and physics the second semester; a one-semester course in the science of the human body; a one-year course in human relations, and two nursing courses.

The second-year curriculum has a one-year course in community problems (taken by all college students) and two courses in nursing. There is allowance for elective courses.

Our major problems are: (1) evaluation—of courses, of individual curricula, of the products of the courses; (2) ratio of students to faculty—we think that stated ratios are invalid; costs—we do not know now what courses in nursing cost.

We are not trying to cut out learning by doing. But we are interested in: amount of doing, way of doing, place of doing, supervision of doing.

Housekeeping's Growing Pains

Mrs. Madge H. Sidney, Executive Housekeeper, Evanston (Ill.) Hospital—The tremendous growth in hospital housekeeping duties in the last five years has made it essential for housekeepers to plan for more education and higher standards for the field.

Reasons for this rapid growth are: (1) growth of hospitals as a whole; (2) shortage of nursing and other personnel; (3) introduction of new programs within the hospital; (4) difference in the personnel market of today, and (5) acceptance of new and greater responsibilities by executive housekeepers.

When housekeeping takes over some nursing duties, housekeeping employees come in contact with the patient, and therefore have problems in public relations. Hence, the executive housekeeper must teach her personnel good public relations, or simply good manners.

(Continued on next page)

Below: Gay scarves and Indian headdresses added to the party mood. In this group at the Paul Bunyan party were (l. to r.): Lona G. Jacobson, M.T., and Marie E. Jarshaw, R.N., administrator, both of Falls Memorial Hospital, International Falls, Minn.; Cecil Hamiter, student in hospital administration, University of Minnesota, Mrs. Robert Scheele, president of the auxiliary, and Mrs. Lena Rowan, business manager, Falls Memorial Hospital. TOPICS' photos by Marie Jett.

Mrs. Harold K. Wright appears to be threatening her husband (r.), superintendent, Methodist Hospital, Sioux City, Ia., and past president, Upper Midwest Hospital Conference, 1950-51, with a miniature hatchet—souvenir of the Paul Bunyan party. At l. is Harry C. Wheeler, superintendent, Deaconess Hospital, Billings, Mont., president, Upper Midwest, 1951-52. In picture above are Glen Taylor, executive secretary, Upper Midwest, and Raymond K. Swanson, superintendent, The Swedish Hospital, Minneapolis, outgoing president of the conference. Mr. Swanson was succeeded by Louis B. Blair, superintendent, St. Luke's Methodist Hospital, Cedar Rapids.

Establishment of accident and fire safety programs has meant much additional work for the executive housekeeper. She must help plan evacuation programs for each area, and for the different types of patients. The newborn, the ambulatory patients, the polio victims in respirators—all present different evacuation problems. Fire code systems must be set up, and there must be constant check-ups on safety and fire safety hazards.

Personnel is one of the biggest problems. Unless we institute good training and in-service programs and give our people pride in their work, we will continue to get "the leavings" and to have a constant turnover in employees. Assistants and supervisors must conduct these educational programs. Unfortunately, many of them have not had the educational advantages they need.

For our new and greater responsibilities we need a knowledge of such things as blue prints and interior decorating, sanitation, technics for cleaning in contaminated areas, and the conductive operating room floor.

We can gain for housekeeping the professional standing which nursing and dietary have, but we must earn that standing by setting up a program for higher standards.

In England some effort has been made to raise educational standards. The Institutional Management Association offers a two-year training course which covers the theory and practice of cookery, catering, nutrition, business affairs and bookkeeping, institutional management and general applied science, plus practical work in large-scale cooking, catering, and household management. After passing an examination at the end of the second year, the student has a third year of experience as a junior employee in an establishment, then takes a final examination before she receives a certificate.

The drawback in this program is that it combines housekeeping with dietary, and dietary always comes first in such a situation.

We should begin by getting the cooperation of the American Hospital Association and our administrators. Then we should try to stimulate interest of students—from eighth grade on through college—in housekeeping as a career. We should try to hire assistants and supervisors with home economic backgrounds—if possible, with degrees—then see that they get scholarships and financial aid from the hospitals to attend short courses in hospital housekeeping. After eight weeks of concentrated study, they should have enough theory so that they can take a year's training (with pay, of course) under a qualified housekeeper. A few hospitals have accomplished this aim, and we believe we will soon be over our "growing pains."

Hospital Relations with Labor Unions

Kenneth J. Holmquist, Administrator, Minneapolis General Hospital—Once the relationship of unions and hospitals has become more stabilized, labor may be expected to take a constructive role in maintaining good work standards for the ultimate benefit of the patient. Labor and its leaders assume a great responsibility for community health when through their activities they become more influential in hospital policies.

We can expect a continued increase in membership in hospital unions, and a corresponding increase in unions' influence on hospital-employee relationships. Therefore, it seems vital for hospitals to learn methods that will insure labor's cooperation—not only in doing jobs assigned, but in gaining loyalty for the hospital program.

(Continued on page 29)

Students in hospital administration at the University of Minnesota, shown in a gay mood at the Paul Bunyan party, are (l. to r.): Hamilton Reid, Woodrow Lee, Bruce Sanderson, Eugene A. Brim, Carl Streufert, Ward A. Stoddard, and John M. Hendricks.

To have good relationships with its employees, hospital management must recognize those employees as individuals. Unionism's appeal is not just in its offer of greater economic security, but in its recognition of its members' desire to be considered and respected as individuals.

Each worker wants the security found in steady employment; a chance for advancement; treatment from his supervisor and associates that makes him believe he has a personal stake in the hospital's success, and assurance that his work is going to be justly evaluated and appreciated.

An employee must know what is expected of him in his job. Job listing is not enough. There should be a planned program of pre-service training to orient the employee to hospital policies and functions and work methods. There should be adequate supervision and opportunity for in-service training.

Grievances seem to be more frequent after unionization of a hospital than before. One reason for this is that employees are more likely to express their minor grievances through the medium of the union, instead of keeping quiet and brooding over them. It is better for problems to be brought out in the open, even if solutions cannot always be found.

Civic projects—which may or may not be related to hospital operation—may benefit from the existence of labor organizations in hospitals, because unions have given support to Community Chests, Red Cross blood drives, savings bond campaigns, and other activities.

Administrator-Purchasing Agent Relationship in Small Hospital

Gilbert L. Cake, Administrator, St. Lucas Deaconess Hospital, Faribault, Minn.—Centralization in purchasing is necessary if the greatest efficiency and potential savings are to be realized. Unfortunately, 100 percent centralization is rarely attained by small hospitals, and sometimes not by large ones.

In the small hospital, the administrator, even though he has delegated purchasing duties to one or more individuals, must still be responsible for the end result. He may have designated someone to do an important job who lacks necessary technical knowledge or business instinct to perform those duties, and he therefore has the responsibility of helping that person in every way possible.

The administrator should teach whoever is doing his buying to have respect for good salesmen and not to keep them waiting a long time when they make their calls. A buyer who establishes a good relationship with salesmen will find them not only helpful and willing but in a position to provide information which sometimes is not available from any other source.

Mrs. Josephine Poehler (l.) chairman, Minnesota district, American Association of Medical Social Workers, and administrator, Sheltering Arms Hospital, Minneapolis, shows literature on medical social workers to Mrs. G. S. Petterson, auxiliary, Immanuel Hospital, Mankato, Minn.; Mrs. R. F. Bilstein and Mr. Bilstein, administrator, Bismarck (N. Dak.) Hospital.

Attending institutes and meetings, particularly the institutes on hospital purchasing conducted by the American Hospital Association, is a good method of acquiring both general and specific knowledge in hospital procurement. At our hospital we have encouraged attendance at these institutes by giving a day off with pay to all employees who attend. We feel that if they only look at the exhibits to see what is new and realize that there are other ways of doing things, their trip is worthwhile.

Information on purchasing can also be obtained from visiting other institutions and from reading publications, particularly the manuals available through the American Hospital Association. Commercial publishing houses have several manuals dealing with textiles, which represent an important item in the cost of supplies.

Because of the great variety of items with which we must deal, we can hope only to acquire a broad, general, comprehensive knowledge of materials. We don't need to remember a lot of figures; we need only to know where to go to find information.

Sometimes the administrator will have to make the final decision on a purchase. He may have to decide on a purchase. He may have to decide whether price will be the determining factor, or whether abstract and esthetic

(Continued on page 30)

Alma Laumbach, R.N., and Zipora Braunschweig, R.N., secretary, Upper Midwest Hospital Conference Nurse Anesthetists' Association both from McCrary-Rost Hospital, Lake City, Ia., meet fellow Iowan Roland B. Enos, administrator, Cedar Valley Hospital, Charles City, Ia. At r.: Speakers at the sectional meeting for purchasing agents were (l. to r.): Gilbert L. Cake, administrator, St. Lucas Deaconess Hospital, Faribault, Minn.; Boyd A. Sanderson, assistant administrator and purchasing agent, St. Barnabas Hospital, Minneapolis; and Franklin Carr, administrator, Waukesha (Wis.) Memorial Hospital.

Maternity Nursing Session Included on NLN Program

● Two special sessions on maternal and child health nursing will be held June 22, during the first convention of the National League of Nursing, which is meeting in the Public Auditorium, Cleveland, from June 22-26.

Whether to form an interdivisional council on maternal and child health nursing will be one of the major decisions made at the convention. Anna Fillmore, R.N., general director, National League for Nursing, New York City, will talk at the afternoon session on "What Are Interdivisional Councils and What Do They Do?"

Ruth G. Taylor, chief, nursing section, U. S. Children's Bureau, Washington, D. C., will lead a panel discussion on "Working Together for Healthier Mothers and Children." Members of the panel will be: L. Louise Baker, R.N., director of nursing, Children's Hospital of the East Bay, Oakland, Calif.; Nicholson J. Eastman, M.D., obstetrician-in-chief, The Johns Hopkins Hospital, Baltimore; Helen E. Hallfors, R.N., assistant professor of pediatric nursing, Frances Payne Bolton School of Nursing, Western University, Cleveland; Aileen Hogan, R.N., Maternity Center Association, New York City; Florine N. Thomason, R.N., chief nurse, Richmond (Va.) Public Schools Medical Department; and Violet Knistle, R.N., director of nursing and physical therapy, State Services for Crippled Children, State University of Iowa, Iowa City.

"The Mental Hygiene Role of the Nurse in Maternal and Child Care" will be discussed at the morning session by Gerald Caplan, M.D., lecturer in mental health, School of Public Health, Harvard University.

The American Committee on Maternal Welfare will sponsor a luncheon at the Hotel Statler Monday noon. Allen C. Barnes, M.D., recently appointed chairman, department of obstetrics and gynecology, Western Reserve University, will talk on "The Mutuality of Purpose of Doctors and Nurses in the Maternity Field." Advance reservations for the luncheon may be made with the American Committee on Maternal Welfare, 116 S. Michigan Ave., Chicago, Ill.

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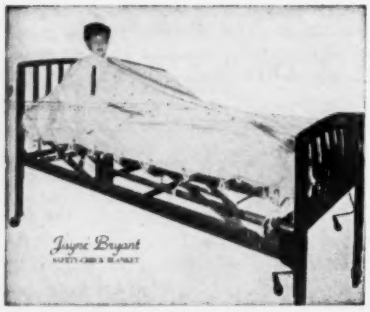

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values must be considered. Paying a little more for decoration or equipment may be very worthwhile if patients are more comfortable and more contented as a result of its purchase. One hospital which had been using Hi-Lo beds for some time reported recently that they were still receiving requests from incoming patients for rooms equipped with those beds. The prospective patients had either seen the beds as visitors or had been told about them by friends who had been hospitalized.

The administrator often will have to originate ideas for effecting savings in many operations, unless he is fortunate enough to have unusually well-qualified personnel in his mechanical departments. For example, he may find it possible to save quite a sizable sum by renovating a water softener. The maximum life of a softener using the old type fills is supposed to be 10 to 15 years, but efficiency decreases very rapidly after one year of operation. After five to 10 years of operation, the operating cost may be far out of proportion to the quantity of soft water obtained per regeneration.

We replaced our 10-year-old fill with the resinous bead mineral fill (trade name—Zeolite). Although it, like the old types, has an affinity for iron, it can be treated with a sulfuric acid bath, the iron removed, and the material used indefinitely.

The new fill cost us just over $1,000. Capacity was increased four times, from 16,000 to 64,000 gallons per regeneration. We expect to reduce our operating cost by 50 percent, and this saving will pay for the installation in less than four years. This figure doesn't include savings which undoubtedly will be brought about in the laundry and in other departments in which the use of really soft water is very desirable.

In purchasing, the administrator should try to take a commonsense middle course—between the practice in which the emphasis is strictly on dollars and cents and the other extreme in which emotion has more influence on buying than clear thinking and practical facts.

All photographs by TOPICS

Tri-State Hospital Assembly

8,000 Registration Makes 23rd A Record-Breaking Convention

● A registration of over 8,000 hospital people made the 23rd annual Tri-State Hospital Assembly a record-breaking meeting. The Assembly, which serves the mid-continent, is comprised of 34 sections and is sponsored by the state hospital associations of Illinois, Indiana, Michigan, and Wisconsin. Some of the papers presented during the three full days of meetings are abstracted on the following pages.

Assembly Confers Four Awards at Annual Banquet

Keys for meritorious service to the sick and injured were presented to a nominee from each of the sponsoring states at the annual banquet. The presentations were made by Malcolm T. MacEachern, M.D., Director of Professional Relations of the AHA, and chairman of the Assembly.

Winners are shown in the picture above. Left to right, they are: Michigan, Ronald D. Yaw, Director, Blodgett Memorial Hospital, Grand Rapids; Indiana, Robert E. Neff, Superintendent, Methodist Hospital, Indianapolis; Illinois, Stuart K. Hummel, formerly Administrator, Silver Cross Hospital, Joliet, but recently appointed Administrator, Columbia Hospital, Milwaukee; and Wisconsin, Nels E. Hanshus, Manager, Luther Hospital, Eau Claire.

Progress in Long-Term Care

Ben Grossman, Director, Drexel House for the Aged, Chicago—The needs of the old are many. The only way that most of these needs can be met is by considering each person as an individual. Each must have the opportunity of self-expression.

People living in a home for the aged must feel that they are having a share in running

Above: These sisters, all from the Divine Infant of Prague Hospital, Wakefield, Mich., are (l. to r.): Sister Mary Kinga, R.N., general duty nurse; Sister Mary Adeline, administrator, and Sister Mary Anselm, R.N., anesthetist.

Above: Winners of cash prizes at forum for ideas on improving efficiency were (r.): Mrs. Madge Sidney, executive housekeeper, Evanston (Ill.) Hospital, who won first prize of $15; (l.) Fern Brown, director of dietetics, Reid Memorial Hospital, Richmond, Ind., and James E. McNelley, assistant administrator, Elkhart (Ind.) General Hospital, who received the second and third awards of $5 each.

Below: Speakers on accounting section program were (l. to r.): John M. Stagl, assistant director, Passavant Memorial Hospital, Chicago, and president, American Association of Hospital Accountants; David H. Spanier, organization and methods examiner, hospital methods improvement branch, Office of the Surgeon General, Department of the Army, Washington, D.C.; and Howard J. Wassenaar, assistant director, Edward J. Sparrow Hospital, Lansing, Mich., and chairman, hospital accountants' section.

that home. We formed several committees on which the residents serve. We have committees for residents, grievances, visiting sick, recreation, co-occupational therapy, editorial, reception, and temple or church.

The type of person who needs a home for the aged is changing. He is older than his predecessor and because of his advanced age is apt to need more medical care.

There are many considerations to be made for residents. There should be: regard for the individual's privacy; opportunity for self-expression; facilities for social, recreational, educational, and religious life; good food and sanitation; a monthly allowance for each resident; adequate safeguards for protection of life and limb; work opportunities, and provision for social and psychiatric services for the people who live there.

Organizing Outpatient Clinic

Russell Duncan, Administrator, Carle Memorial Hospital and Clinic, Urbana, Ill.—To organize and run a top-notch outpatient department, we must take into consideration the personalities of our star players—the doctors. We must remember that doctors are individualists.

There are two possibilities in setting charges for space: (1) charge according to the number of patients a doctor may see or (2) charge for the amount of space he may require. A charge based on the number of patients would seem more equitable. However, if the second method is used, the charges should be in accordance with charges for similar office space in other parts of the city.

A common appointment desk is a good idea—not only for x-ray and laboratory patients, but for general patients as well. The community could be served better, because appointments could be made over a longer period of time.

A large general lobby could accommodate all outpatients, or several small lobbies could be used. If a general lobby is used, a master list of patients should be available at the desk.

I believe the organization needs a cashier. Each doctor could be asked to make duplicate charge slips—one to go to the cashier and one to remain in the doctor's files.

If we can enlarge our outpatient departments to include diagnostic medicine, our hospital will become the medical center of the community.

Availability of Personnel for Nursing Service

Marion W. Sheahan, Associate Director, National League for Nursing, Inc., New York—Statistics show that the supply of nurses has increased in the last 30 years, but they also show that the supply has not kept pace with the demand.

Today there is an increased number of graduate nurses, but the hospital shares those graduates with the community. There are now 14,300 nurses in industry; work in doctors' offices and public health nursing take another large portion.

The shortage is also caused by the shift in meaning of nursing. The complexity in medicine has meant an increase in certain treatments given by physicians, the patient stay is shorter, and nursing has expanded care during illness to include teaching the patient to care for himself after he leaves the hospital.

There is no ready answer to increasing nursing personnel. Recruitment has become difficult. In 1920 girls had only two choices, either a career in nursing or in teaching. Today there are 50 occupations competing for the high school graduate. In order to keep pace nursing must be given a modern concept.

Above: George K. Hendrix (l.), chief, bureau of hospitals, Illinois State Department of Public Health, Springfield, listens with interest as George H. Van Dusen, D.D.S., administrator, Christian Welfare Hospital, East St. Louis, and president, Illinois Hospital Assn., talks over association problems with the president-elect, Russell H. Duncan, administrator, Carle Memorial Hospital, Urbana, at the Illinois breakfast. At r. is Leonard W. Hamblin, administrator, Deaconess Hospital, Freeport, Ill.

Above: Members of this relaxed group were (l. to r.): William Miller, assistant superintendent, Cleveland City Hospital; Marie Jett, associate editor, HOSPITAL TOPICS; and William E. Smith, executive director, Hospital Industries' Assn., Chicago.

Below: Singer Kitty Kallen and Malcolm T. MacEachern, M.D., try out the new bed occupancy monitor developed by Executone, Inc., in cooperation with E. M. Bluestone, M.D., consultant, Montefiore Hospital, New York City, and E. D. Rosenfeld, M.D., director, Long Island Jewish Hospital, New York City. The device, when attached to a hospital bed and connected to the audiovisual nurse call system, will sound an alarm at the nurse's station when a patient is overly active or attempts to get out of bed.

Nursing loses 33 percent of its 102,000 students each year. If we could cut this to 10 percent we would gain 10,000 additional nurses. Better counseling in filling enrollments will help.

Future of Nursing Education

Robin C. Buerki, M.D., Executive Director, Henry Ford Hospital, Detroit—There is still a place for the three-year school of nursing in a hospital which has good standing. There are two reasons why the three-year school must be maintained.

1. If the same hours of education are to be given in two years, quality of education cannot be given without increasing cost to the patient.

2. We will offend graduates of the three-year course when we say that what they learned can now be condensed to two years.

Mechanical nursing can be justified if the time spent in making beds and making the patient comfortable is used to promote patient relations and help the patient psychologically.

There is more room for graduate work if the nurse wants additional education in order to specialize as does the doctor.

Emphasis should not be placed on the number of hours spent by the student in one particular study but on the quality of the education received. I make this a plea for quality education.

Hospital's Concern in Trends of Nursing Care

Eva H. Erickson, R.N., Administrator, Galesburg (Ill.) Cottage Hospital—The hospital is concerned with two trends. First, the increased and intensified duty of the nurse to gain economic security. There has been an attempt to get the Taft-Hartley Act to cover the hospital. Bringing the union into the hospital will complicate the hospital program and eventually cause harm. Nurses will become more interested in money than in service. Many nurses have no idea where money comes from to pay their salaries. Increase will mean greater cost to the patient.

The second trend of concern to hospitals is the graduate nursing shortage. The accreditation program will not help to get more nurses. Its activity is closing schools. Less nurses will graduate unless approved schools increase their enrollment. Concern is for the small hospital in rural areas. The greater part of the enrollment of small schools of nursing come from the surrounding area and these students remain in the area. What is to insure the return of these students to the small hospital if they attend schools in the large medical centers?

The role of the hospital now is that of a begger. The shortage has created a good bargaining situation for nurses since the hospital must give anything and everything in order to obtain them.

The Administrator Looks at Personnel

Edward J. Logan, Director, Milwaukee (Wis.) Children's Hospital—Ingredients for a sound personnel program are:

1. Organization framework — established responsibilities, functions, and authority. Each department should have a list of approved positions for each person in the department.

2. Written personnel policies specifying working conditions, hours, vacation, sick leave, transfers, etc.

3. Sound practices concerning recruitment, selection, and placement of personnel.

4. Acceptable working conditions for employees.

(Continued on next page)

5. Job analysis—to provide information, detailed duties, and objectives of each job to employees.

6. Job evaluation—ranking all jobs to arrive at an equitable salary scale. Salary scales should be consistent and reviewed annually.

7. Communications with employees through bulletins, handbooks, house organs, etc.

8. Training and orientation program for new employees.

9. Health and safety program within the hospital should be made known to new personnel.

10. Rules and regulations which should be understood and obeyed by all employees.

11. Terminate interviews should be granted to determine cause of the employee leaving the hospital.

The main objectives of these points are: to get good employees, to find out how to keep them, and to get the most out of an employee. In order to reach these objectives the administrator must take a personal interest in each employee, and be on the job 24 hours a day.

The Role of the Anesthesiologist

John H. Hunt, Executive Secretary, American Society of Anesthesiologists, Chicago — Because this is a new field, trustees and others fail to realize the scope of activities of this trained person.

A recent movement on the part of anesthesiologists has been to change from being a hospital employee to practicing on a fee-for-service basis. This basis is used by 83.5 percent of the members of the American Society of Anesthesiologists.

It is accepted that the doctor's responsibility is solely to the patient and no third party should be involved. When a doctor is employed by a corporation that corporation functions between the doctor and the patient and could thus control the practice of medicine.

It is argued that in many hospitals doctors are not permitted to bill patients and hence a higher type of medicine is practiced. This may be true but it does open the way to lay control of medicine and exploitation in short-sighted and unprogressive institutions. Rules are drawn for the minority.

In many cases the anesthesiologist and the hospital are satisfied with a fee-for-service basis, but this method is considered unhealthy for the patient.

Difficulties are not unsurmountable but the administrator, medical and surgical staff, and trustees must understand the facts in order to eliminate them.

Selling the Pharmacy Department

Paul Bjerke, Chief Pharmacist, Luther Hospital, Eau Claire, Wis.—There are several methods by which the pharmacist can sell his department within the hospital. He can strive to be a consultant to the medical, nursing, and house staffs. In assuming this role he should establish a library to encourage visits from the medical staff. The pharmacists can interpret and compare products for the physician.

A second step is to issue a news letter from pharmacy to convey information to the medical staff. This has been done in my hospital and so far has proved very worthwhile.

A selling job can be done by writing articles and giving talks on pharmacy.

An important phase of gaining cooperation is a teaching program for the intern and resident staff. Conferences can start on prescription writing, use of antibiotics, hormone products, sedatives, etc.

The pharmacist also has a responsibility to the nursing staff. A literature file should be available for use by graduates and students. Nurses should be encouraged to consult with the pharmacist on problems of technic, how to administer dosage forms is an example.

The pharmacists must be able to meet the challenge of the rapid changes in medicine and be ready to render service where it is needed.

Elements of Administrative Practice

Elmore Petersen, LL.D., Dean, School of Business, University of Colorado, Boulder — The administrator's task must include: formulation of plans and purposes; making of decisions; communication of those decisions to hospital personnel; securing performance, and exercising leadership.

His general plan—patient care—is already determined for him. His decisions depend on his knowledge and judgment, and must of course be made in view of existing circumstances. Effective communication of decisions to personnel is essential, since the administrator cannot do the work of the hospital himself. The administrator must understand the proper selection, training, motivation, and compensation of his personnel. Communication means delegation of authority to others. Authority and responsibility should be co-equal.

Unless the administrator can get satisfactory performance from his employees, he is a failure. Performance depends upon motivation — and recognition is a greater incentive than remuneration.

The whole task of the administrator can be summed up in leadership. He must liberate the capabilities and potentialities of his employees. He must not ask them to do things beyond their ability. At the same time, he has the responsibility of increasing their usefulness—expanding their "restricted wisdoms"—by training programs. Not only is it wasteful to neglect to utilize abilities, but it results in inertia and perhaps in frustration.

Geriatric Care Must Be More Individualized

Adalbert Dierks, Student in Hospital Administration, Washington University, St. Louis—Because of the anticipated greater number of elderly patients in the future, the hospitals of tomorrow will need geriatric departments adequately equipped and staffed with personnel trained in geriatric care.

Hospitals must be prepared to give adequate occupational therapy, recreational therapy, and bibliotherapy to older people. To be most beneficial, this care cannot be standardized, but must be suited to the needs of each individual patient.

The occupational therapist must provide activities that will be of personal and social satisfaction. Treatment must be continuous to be of lasting value. Because some old people may not want therapy, the therapist will need effort and understanding to revive their interest in life.

Varied facilities should be available for recreational therapy. A proved treatment for one patient may not meet the needs of another patient. At present, recreational therapy programs are limited by the inadequate number of experienced and qualified personnel. Progressive hospitals must take the lead and train an increasing number of therapists.

Bibliotherapy—the prescription of suitable reading materials—can help to develop emotional maturity, and to nourish and sustain mental health.

The economic problem of an aging population cannot be overlooked. Its solution will be found in part in the pre-

(Continued on page 36)

Left: Among Chicagoans at the Illinois Hospital Association's breakfast were (l. to r.): H. S. Hansen, director, Grant Hospital; Martin H. Hough, Augustana Hospital; Niles G. Axelson, Elmer J. Anderson, and Carl Lindstrom, Swedish Covenant Hospital; Clyde L. Reynolds, administrator, Provident Hospital; Ernest E. Schmidt, president of the board, Grant Hospital; and Carl D. Rinker, assistant director, Grant Hospital.

Right: Members of the panel who discussed hospital building and furnishings were (l. to r.): John N. Hatfield, Chicago, director, Passavant Memorial Hospital; Robin C. Buerki, M.D., executive director, Henry Ford Hospital, Detroit; Roy Johnson, Evanston, Ill., section chairman; Herman Smith, M.D., hospital consultant, Chicago; and Carl A. Erikson, Schmidt, Garden and Erikson, Chicago.

Above: Speaking on problems of establishing or expanding the small hospital were (l. to r.): D. T. Bunting, vice-chairman, board of trustees, Fairfield (Ill.) Memorial Hospital; J. Gordon Dandignac, administrator, Dickinson County Hospital, Iron Mountain, Mich.; Olive M. Murphy, R.N., administrator, Bartholomew County Hospital, Columbus, Ind.; Kenneth D. Moburg, administrator, Schoolcraft Memorial Hospital, Manistique, Mich.; and Vincent F. Otis, director, Division of Hospital and Related Services, Wisconsin State Board of Health, Madison.

Below: At the speakers table at the annual administrators' luncheon, given by the American College of Hospital Administrators, were (l. to r.): the Rev. Joseph A. George, superintendent, Evangelical Hospital, Chicago; Herman Finer, D.Sc., professor of political science, University of Chicago, who spoke on "The Science of Administration"; and Ernest I. Erickson, superintendent, Augustana Hospital, Chicago, and immediate past president, ACHA.

Below: Convention registrants crowded around TOPICS' booth at meeting to get souvenir photographs.

ventive and curative measures which must be taken to maintain maximum health and usefulness in old age.

Plans for the care of the aged, besides providing for necessary physical facilities and equipment and specialized training and knowledge required of personnel, should also include a program of education for the middle-aged people of today—the old people of tomorrow.

Architect's Approach to Designing and Building a Hospital

Carl A. Erikson, Schmidt, Garden and Erikson, Architects, Chicago—The first thing to consider in selecting an architect is his whole personality, which dictates his approach. An architect must never be a yes-man. However, he must be able to take criticism and sort out the pertinent part.

In building a hospital, there is a need to determine what the impact of medical progress will be on the hospital, and particularly on the medical service. Will the medical laboratory service increase at the rate it has during the past 20 years, or can we anticipate a sloughing off?

Hospitals which do not prepare their service departments for greater capacity than is expected at present are making a serious mistake. The good architect will design those departments to allow for future expansion.

The first step the architect should take is to plan the nursing unit, which is the foundation of all hospital planning.

It is important to provide outpatients with easy and direct access to medical service departments, since they will be frequenting almost all departments except surgery and delivery rooms.

Consultant's Approach to Planning

Herman Smith, M.D., Hospital Consultant, Chicago—In hospital planning, start with the patient's bed. What do you want around the patient's bed? Good facilities for the patient—facilities which will enable the staff to give the best possible care and cut stays as short as possible. An example is the audiovisual call system, which saves time of nursing personnel.

Economy can be effected by efficient planning of nursing units. Two 30-bed units cost the hospital $8,000 to $10,000 a year more than one 60-bed unit, because of the additional graduate nursing staff required.

Central supply needs to be incorporated in detail throughout the hospital. Everything possible should be around the patient's bed, and central supply should be incorporated on each floor.

If you haven't adequate space, don't build the hospital. You must have room to expand.

Hospitals Should Be Operated As Efficiently as Business

D. T. Bunting, Vice-Chairman, Board of Trustees, Fairfield (Ill.) Memorial Hospital—The members of our board are businessmen. We figure that we are in a competitive business, and that we must satisfy our customers.

A hospital should operate in the black, but not at the expense of the patient. Our prices must be aligned with those of our competitors in order to attract business.

We started with all bills paid and $30,000 in the bank. Although the state department of health had predicted a loss of $30,000 in the first year of operation, we lost only about $2,700.

Every two months we meet with the medical staff and have a medical and surgical audit, because we feel responsible to the public for the kind of medicine and surgery practiced in the hospital. We are not qualified, of course, to pass on the audit, but we are able at least to make some intelligent inquiries as to why certain items are over the general average.

Our medical staff members realize their limitations. They are not specialists. Consequently, we have arranged for specialists to come from St. Louis to give lectures and advice and to discuss various cases.

To "sell" our hospital to the public, we encourage gifts of all kinds. We believe that raising money for hospital construction by public contribution was of great assistance in getting "boosters" for the hospital.

Administrator's Approach to Building a Hospital

John N. Hatfield, Director, Passavant Memorial Hospital, Chicago—Timing is one of the most important parts of a building program, in order to have equipment and furnishings arrive at the same time for installation.

The administrator has a vital role in trying to keep his department heads on the right track in building and equipping the hospital. It can be a real problem to prevent these people—particularly the staff doctors—from employing set-ups which require special or off-standard equipment. The consultant and architect will be helpful in the solution of this problem.

On the other hand, the administrator can and should help the architect and consultant by advising them of local practices with regard to use of equipment and patient facilities, or any peculiarities in that particular hospital situation which should be taken into consideration in planning the hospital.

Equipping the Small Hospital

J. Gordon Dandignac, Administrator, Dickinson County Hospital, Iron Mountain, Mich.—The person charged with the responsibility of equipping the small hospital must be concerned with getting an adequate quantity of equipment and equipment which is durable, standard, and adaptable—of such quality as to assure maximum performance.

No one department should have elaborate equipment at the expense of other departments. Equipment needed is going to vary. Sometimes it may vary a great deal, depending on the services which the hospital is going to render.

Primary requisites for the job of equipping a hospital are: (1) knowledge of hospital supplies and equipment and (2) understanding of the needs of the hospital patient.

The person who is equipping a new hospital would be wise to consult with personnel in other hospitals in the community, since he is not sure who will staff his hospital.

Operating Financing in Small Hospital

Kenneth D. Moburg, Administrator, Schoolcraft Memorial Hospital, Manistique, Mich.—When we started operation, we had been advised that a first-year subsidy of $10,000 to $15,000 would be necessary. However, in the first year, our expenses exceeded our income by only about $6,000. In the second year, income exceeded expenses by $5,000, and in the third year, income was $12,000 more than expenses.

Some of the questions which must be considered in financing are: What type of hospital and medical care are people in your community accustomed to having? How close are neighboring facilities? Does the community make only limited use of the hospital? Are the local physicians capable of using the hospital facilities, or do they merely use the hospital as a nursing home? In a small hospital, lack of complete utilization of the facilities by all physicians in the community will mean the difference between profit and loss.

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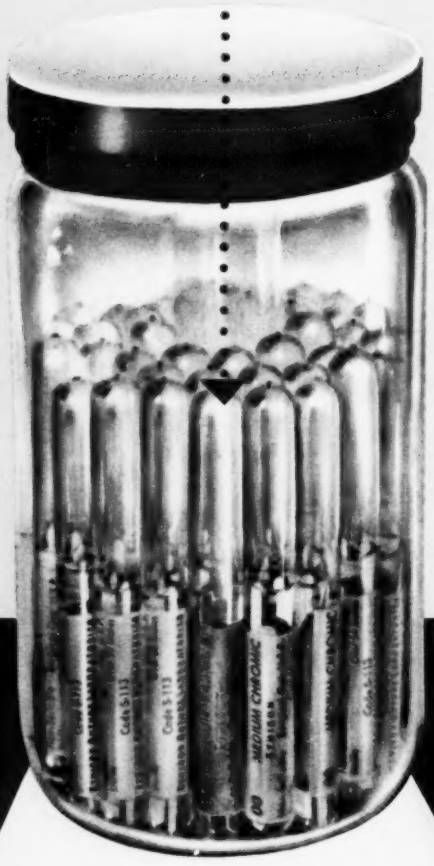

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Review of Hospital Law Suits

By Leo T. Parker

Attorney at Law, Cincinnati, O.

● A reader inquired: "What are the usual requirements that a charitable hospital corporation must comply with and fulfill in order not to be held liable in damages for injuries to a patient caused by negligence of an employee?"

According to a leading higher court decision a charitable hospital is not liable for negligence of an employee, if the testimony shows that the officials of the hospital exercised reasonable and ordinary care to select competent employees.

For example, in Weiss vs. Swedish Hospital, 133 Pac. (2d) 978, it was disclosed that a patient in a charitable hospital began to have birth pains. She summoned her physician who took her to the delivery room, placed her on the delivery table, and strapped her wrists. A nurse in the hospital began giving the woman ether to keep her in labor and relieve her pain. Shortly after, she found it necessary to leave the room temporarily. She summoned an intern to care for the woman and went to the other room to attend to her supervisory duties, instructing the intern to continue the administration of the anesthetic, as the circumstances might require. Shortly thereafter, the intern found that the ether container was nearly empty, and, as the patient was quiet, he turned to get another can of ether from a row of shelves behind him. While he was thus engaged, the patient pulled her hands out of the straps, fell off the table, and sustained severe injuries for which she sued the charitable hospital. The higher court held the hospital not liable, and said:

"Since we find that the respondent is a charitable corporation, that no administrative negligence is shown, and that those of its servants who were alleged to have been guilty of negligence were selected with due care, we must affirm the judgment of dismissal entered by the trial court, unless we depart from the long-settled rule hereinbefore stated."

PAYING PATIENT IN CHARITABLE HOSPITAL

Another important point of modern law recently decided by a higher court, is that a paying patient in a charitable hospital has no greater right to sue and recover damages for negligent injury, than has a charitable patient. In other words, the courts hold that one who accepts the benefit, either of a public or a private charity, enters into a relation which exempts his benefactor from liability for the negligence of his servants in administrating the charity.

For example, in Jur vs. Dieu, 11 So (2d) 623, it was shown that a widow filed suit against a charitable hospital for $15,000 for the death of her husband. She alleged and proved that a nurse who was in charge of the charitable hospital disregarded the physician's instructions as to adminstering a sedative, and performed other negligent acts as a result of which her husband died. The widow, also, proved that her husband had been admitted to the hospital as a pay patient. She argued that although a charitable hospital ordinarily cannot be held liable in damages for negligent acts of attendants and employees, since this hospital corporation was accepting money as payment for services rendered her husband, such hospital should be held liable for negligence of its employees to the same degree as are other institutions which operate profitably.

The lower court agreed with these contentions and held the charitable hospital liable. However, the higher court reversed the decision and held the hospital not liable. This court said:

"Institutions which furnish hospital accommodations and medical attendance to different classes of patients, some for pay and others free of charge, not, however, for making money or profit, but for benevolent and charitable purposes exclusively and whose entire receipts and revenues are devoted to such purposes, are not liable even to pay patients, for the errors or negligent acts of competent employees."

HOSPITALS AND PHYSICIANS LIABLE

A reader asked this question: "If two or more persons, and hospital attendants, cause an injury to a patient, can the court hold only one liable in damages to the injured patient?"

According to a late higher court decision, all negligent persons are liable, including the hospital.

This is so because, in a modern hospital a patient is quite likely to come under the care of a number of persons. The courts hold that all, including the hospital corporation, are jointly responsible if "reasonable" care is not used to protect and safeguard a patient.

For example, in Barra vs. Spangard, 154 Pac. (2d) 687, it was shown that a patient consulted a physician, who diagnosed his ailment as appendicitis, and made arrangements for an appendectomy to be performed by a surgeon at the hospital. The patient entered the hospital, was given a hypodermic injection, slept, and later was awakened and wheeled into the operating room. After the operation he discovered that he was unable to rotate or lift his arm, and had developed paralysis and atrophy of the muscles around the shoulder. He sued the physician and the hospital for damages. This court held:

"We merely hold that where a plaintiff receives unusual injuries while unconscious and in the course of medical treatment, all those defendants who had any control over his body or the instrumentalities which might have caused the injuries may properly be called upon to meet the inference of negligence by giving an explanation of their conduct."

For comparison, see Lamar and Smith vs. Harmon, 200 S. W. (2d) 845. Here the testimony showed that an ambulance was being driven at a high rate of speed when it collided with a street car, causing serious injuries to a patient in the ambulance. The patient sued both the ambulance operator and the street railway company for damages.

During the trial, testimony was given that at the time of the accident, the ambulance was being driven faster than an ordinarily prudent person would have driven it. Also, the street car operator did not give the ambulance the right of way.

The higher court held that the railway company and ambulance operator must each pay one-half of the total damages awarded or $5,650. This court said:

"The weight of authority supports the general proposition, that, where the negligence of two or more persons concur in producing a single injury, then such persons are jointly liable."

(Continued on next page)

I was asked: "When and under what circumstances is a hospital liable for theft of valuables, clothing, etc., from visitors?"

According to a recent higher court a legal bailee, as a hospital, is not liable for loss or theft of a patient's or visitor's valuables, unless the testimony proves that the loss or theft resulted from negligence of the hospital officials or employees.

For example, in Levesque vs. Nanny, 53 Atl. (2d) 703, the testimony showed that there was a row of hooks on the wall with other clothing hanging thereon. A visitor removed her coat and hung it on the rack. Later she went to the rack for her coat, and found it had been stolen. She sued for the value of her coat. The higher court refused to award the visitor damages, and said:

"A bailee (hospital) is not an insurer. Liability of a bailee does not necessarily follow because there is a loss and no explanation for the loss. There must be evidence of negligence."

Although hospital officials post signs, "Not responsible for loss or theft of clothing, etc.," the higher courts hold that the complaining person may recover the value of stolen valuables, if the evidence proves that a theft resulted from *negligence* of the hospital's employees.

Other higher courts hold that if an employee is kept in employment when the hospital officials know that he has a bad reputation, this fact is evidence of negligence which may result in the hospital being liable.

DOES HOSPITAL PRACTICE MEDICINE

A reader inquired: "Under what circumstances is a hospital corporation liable for illegal practice of medicine? If the hospital corporation accepts part of the profits earned by practicing physicians or surgeons, does proof of these payments result in the corporation violating laws regulating the practice of medicine?"

Generally speaking, the higher courts hold that neither private, nor corporation hospitals can be prosecuted for illegal practice of medicine, simply because fees or part profits are accepted from physicians or surgeons. Of course, if a hospital corporation permits an ordinary employee, not a physician, to prescribe to patients, the corporation may be prosecuted for illegal practice of medicine. Nevertheless, acceptance of fees from physicians or surgeons is not illegal practice of medicine.

For illustration, in Woodson vs. Scott & White Hospital, 186 S.W. (2d) 720, it was shown that a written contract was signed by a physician specialist and a hospital corporation under which the hospital corporation agreed to refer to the specialist various patients requiring specialized treatment, and for which the corporation would receive 25 percent of the profits.

In later legal controversy, the higher court refused to hold that the hospital corporation was illegally engaged in the practice of medicine. This court said:

"Whether or not the hospital, as a corporation, thereby became engaged in the practice of medicine must be determined from the terms of the contract itself."

With respect to whether or not the hospital corporation was engaged in illegal practice of medicine, other testimony was given which proved the general medical and surgical fees were collected by the hospital for several years; the compensation paid by the hospital to numerous physicians and surgeons; statement of the assets, liabilities, and net profits of the hospital; and the employment by the hospital of physicians on a salary basis. All of this testimony was offered as tending to show a

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general plan of operation of the hospital which constituted the practice of medicine by the corporation.

The higher court refused to hold that the hospital corporation was engaged in practice of medicine.

WITHIN SCOPE OF EMPLOYMENT

This question was asked: "If a nurse or other hospital employee suffers an injury, can he or she recover compensation under the State Workmen's Compensation Act, and also sue for damages?"

According to a late higher court decision, the answer is no. This is so because the State Workmen's Compensation Act is intended primarily to relieve employers of damage suits and also assure injured employees of receiving compensation without proof that the injury was sustained as a result of the employer's negligence. However, an employee cannot receive compensation or damages without proof that the injury was sustained within the scope of the employment.

Also, the burden is upon the injured employee to establish by a preponderance of the evidence that the injury was the result of an accident arising out of and in the course of the employment.

For example, in Hammond vs. Doctor's Hospital, 17 N. W. (2d) 9, it was disclosed that a nurse suffered an injury as result of a pin prick on the index finger of her hand. The injury brought on a streptococcic infection that permanently disabled her right hand. She sued for compensation under the State Workmen's Compensation Act, and testified that she was caring for a patient suffering from streptococcic infection when the injury occurred. She stated that the danger of acquiring an infection from such patients was a risk well known to the profession. However, she failed to *prove* by witnesses that the injury or accident was sustained in the course of her employment, and actually when she was caring for a patient. In fact, she did not have the patient testify as to the injury. Therefore, the higher court refused to authorize a compensation award, and said:

"We think the evidence is devoid of proof of a casual connection between the injury and the employment. The compensation law does not constitute the employer an insurer against every accidental injury."

COUNTY NOT LIABLE FOR HOSPITAL SERVICES

Recently, while talking with a hospital official, he asked this legal question: "Is a state, county, or city always liable for payment for hospital services rendered a patient brought or sent to the hospital by authorized public officials?"

According to a late higher court decision, the answer is no. In fact, no public official can obligate a state, county, or city to pay any debt not authorized by proper laws. Moreover, although properly authorized officials incur a debt for a state, county, or city, the debt is not payable if the debt exceeds the debt limitation specified in valid laws, or if no money is left from prior appropriations to pay the debt.

For illustration, Board of Commissioners vs. Ming, 156 Pac. (2d) 820, it was shown that a hospital sued the Board of County Commissioners for money expended for medical and hospital services rendered the poor.

Since no money was left from appropriations to pay for the services, the higher court refused to hold the county liable, saying:

"Positive liability of the county to pay accrues only when a sufficient amount of unexpended and unencumbered appropriations becomes earmarked upon the county records for the payment of some specific item."

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J. T. Gibbons

J. Thomas Gibbons
Vice President and
General Sales Manager

HOSPITAL Trends

BY LOUIS BLOCK, Dr. P. H.

Average Length of Stay

● Of late, much emphasis has been placed on average length of patient stay. In recent years it has shown a marked decrease in general hospitals. Responsibility for this decrease has been attributed to the tremendous strides in the development and use of antibiotics and other changes in medical practice.

How does this decrease affect hospital planning and operation? From the viewpoint of planning, it means that more people can be cared for in the same number of facilities. This fact must be remembered when studying community, state, or national needs. From the viewpoint of hospital operation, it means a tremendous concentration of care into a shorter period of time, resulting in an accompanying increase in personnel to provide such care. This in turn leads to a higher cost of operation and a corresponding increase in costs per patient day.

In short, changes in length of stay have definite planning, staffing, and financial implications for hospitals plus certain community-wide implications. Decreased length of stay means that wage earners are in a position to return to gainful employment earlier, thereby increasing the stability of the labor force and keeping manpower at a higher productive level. It also means that when it is the wage earner who requires hospitalization, there is, on the average, less loss of income. This in turn helps to increase the ability of the patient to pay for care. This latter financial implication is somewhat offset by the increased daily cost of receiving such care.

The term itself means the average number of days of service provided to each in-patient during a specified period of time. For the general hospital, it is computed "by dividing the total number of patient-days (excluding newborn) during a period by the total number of discharges and deaths (excluding newborn) during the same period."[1] For institutions with a long average length of stay, it is recommended that it be determined by using the exact number of days of care given to those patients discharged during that period.

The fact that the AHA makes a classification distinction of hospitals by average length of stay is significant. In doing so, it recognizes certain basic differences in the administration and provisions of services between long-stay and short-stay institutions. Relatively small changes in length of stay have a much more marked effect upon the planning and operation of general hospitals than they have on long-stay hospitals, such as nervous and mental and tuberculosis. For that reason this presentation is limited to general hospitals.

A study of available data relating to length of stay reveals two broad perspectives of approach to the analysis of such information. One is its relationship to disease, and the other to the organizational setting or grouping of the facilities or resources. Regarding the former, there is little available information except from special groups; for the latter more general information is available.

Let us look at the variations which have occurred in general short-term hospitals:

1. Average length of stay is decreasing. This is true for all control groups.

Average Length of Stay (In Days) in General and Special Short-Term Hospitals by Control[2]

	Gen'l & Spec. Short-Term Hospitals			
Year	Total	Non-Profit	Proprietary	Govt.
1946	9.1	8.8	6.6	11.4
1947	8.0	8.1	6.4	9.2
1948	8.7	8.5	5.8	11.0
1949	8.3	8.0	5.6	11.2
1950	8.1	7.7	5.6	10.7
1951	8.3	7.8	5.8	11.1

The longest length of stay occurs in government general hospitals and the shortest in proprietary hospitals.

2. Average length of stay increases with the average size of the hospital. This holds true for all control groups.

Average Length of Stay (In Days) in General and Special Short-Term Hospitals by Size, 1951[2]

	Gen'l & Spec. Short-Term Hospitals			
Size	Total	Non-Profit	Proprietary	Govt.
Under 50	5.7	6.1	5.2	6.0
50-99	6.6	6.7	6.0	6.6
100-249	7.7	7.6	6.7	8.7
250 & over	10.9	9.2	10.2	15.3

3. Average length of stay shows regional variations.

Average Length of Stay (In Days) in General and Special Short-Term Hospitals by Region, 1951[2]

	Gen'l & Spec. Short-Term Hospitals			
Region	Total	Non-Profit	Short-Term	Govt.
New England	9.1	8.6	6.5	13.9
Middle Atlantic	10.2	9.2	7.3	16.7
South Atlantic	7.3	7.1	6.0	8.8
E. N. Central	8.2	7.9	6.9	9.7
E. S. Central	6.7	6.9	5.4	7.1
W. N. Central	8.4	7.9	7.2	11.3
W. S. Central	6.5	6.4	4.8	8.6
Mountain	7.1	6.7	5.2	9.1
Pacific	8.5	6.8	5.3	15.5

4. Average length of stay varies with type of diagnosis.

Average Length of Stay in General Hospitals By Diagnosis, 1951[3]

Medical	16.4 days
Surgical	10.6 days
Obstetrics	6.2 days
Gynecology	8.1 days
Pediatrics	9.0 days
Genitourinary	13.3 days
Orthopedic	15.6 days
Eye, Ear, Nose and Throat	2.1 days
Opthalmology	10.3 days
Other medical services	7.9 days
All patients	10.1 days

(Continued on next page)

Percentage Distribution of Discharges By Length of Stay, 1950

	Rochester, N. Y.		New York City	
Length of Stay	Percentage	Cumulative	Percentage	Cumulative
1 day	14.9	14.9	18.8	18.8
2 days	11.6	26.5	8.4	27.2
3 days	9.7	36.2	6.7	33.9
4 days	10.9	47.1	6.4	40.3
5 days	11.2	58.3	6.2	46.5
6 days	8.6	66.9	5.6	52.1
7 days	5.6	72.5	5.7	57.8
8 days	4.2	76.7	5.3	63.1
9 days	3.5	80.2	4.8	67.9
10-13 days	8.9	89.1	14.0	81.9
14-20 days	5.8	94.9	9.7	91.6
21-30 days	2.7	97.6	4.6	96.2
over 30 days	2.4	100.0	3.8	100.0

5. Average length of stay is not the same for all types of accommodation.

Average Length of Stay in General Hospitals By Type of Accommodation, 1951[3]

Private ..... 9.9 days
Semi-Private ..... 8.9 days
Private Ward ..... 7.6 days
General Ward ..... 12.8 days

6. Average length of stay differs with the financial status of the patient.

Average Length of Stay in General Hospitals By Financial Status of Patient, 1951[3]

Patients paying regular rate ..... 9.3 days
Patients covered by Assoc. Hosp. Ser. ..... 9.0 days
Patients covered by Workmen's Comp. ..... 12.0 days
Patients who are N.Y.C. public charges ..... 14.5 days
Free patients ..... 15.5 days

These variations are important and cannot be disregarded when discussing average length of stay. In addition to their direct application and implications, these differences are important in that they point out the dangers and limitations that are inherent in an overall average. By itself, the overall average only tells part of the story.

Another point of information about length of stay that has a direct relation to hospital operation and patient movement is the proportion of patients that stay in the hospital one day, two days, three days, and so forth. Some special studies made by the Rochester Hospital Council and the Associated Hospital Service of New York reveal that approximately 25 percent of the patients admitted stay only two days; between ½ and ⅔ of the patients are discharged within six days and better than 95 percent within 30 days. The greatest movement of patients occurs within the first five days.

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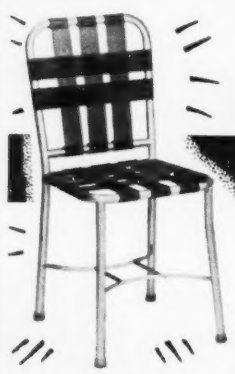

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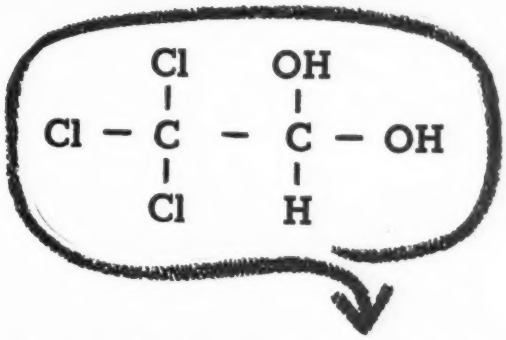

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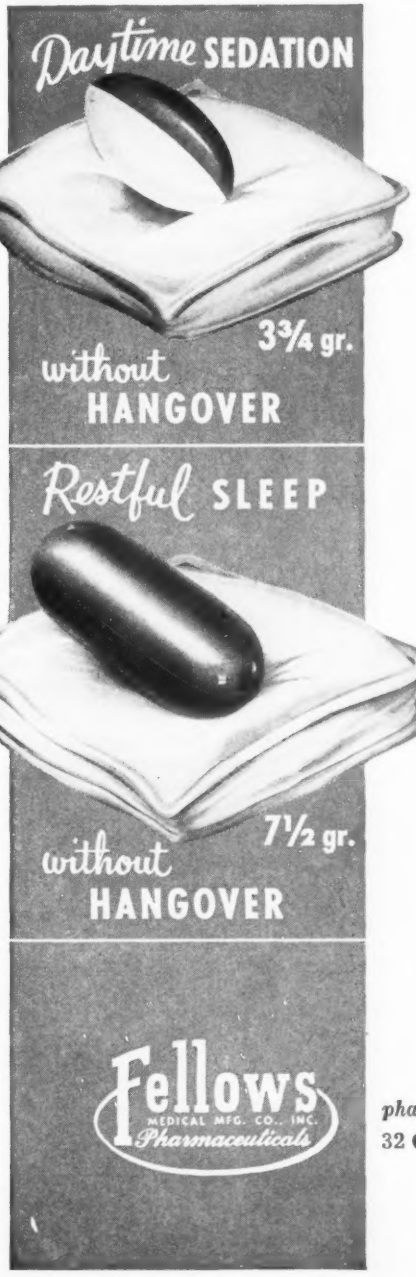

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DOSAGE: One 3¾ gr. capsule three times a day after meals.

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EXCRETION—Rapid and complete, therefore no depressant after-effects.[3-4]

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1. Hyman, H. T.: An Integrated Practice of Medicine (1950)
2. Rehfuss, M. R. et al: A Course in Practical Therapeutics (1948)
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Rx for Reading

By Joseph Peters

Hospitals and Their Medical Staffs

"That physicians and surgeons privileged to practice in the hospital be organized as a definite medical staff. Such organization has nothing to do with the question as to whether the hospital is open or closed, nor need it affect the various existing types of medical staff organization. The word staff is here defined as the group of doctors who practice in the hospital inclusive of all groups, such as the active medical staff, the associate medical staff, and the courtesy medical staff."

—Clause I of the Minimum Standards for Hospitals, American College of Surgeons

● The trustee-medical staff-administrator triad is one of the most complicated relationships in the voluntary hospital. On it hinges the hospital's entire organizational and administrative structure. If the hospital is to discharge its obligations to its patients and to the community at large, mutual understanding and cooperation of the board, the physicians, and the hospital administrator are imperative.

Each hospital has its own particular problems. So far as medical staff organization and relationships are concerned, however, long experience has taught us that certain patterns and principles work better than others. But, even today, it is difficult to lay one's hands on any single recent publication which really presents a complete discussion of this subject.

An annotated listing of some useful references on medical staff organization and relationships follows. It is by no means complete; however, it should provide a good jumping-off point for further readings and study.

"The Board's Control of Hospital Medical Care" bulletin adapted from *Trustee,* AHA, Chicago, 1950.

A noteworthy discussion of trustee-medical staff relationships. Every hospital should possess a copy of this and every administrator should see that it is circulated among the members of his hospital's governing board.

Goldwater, S. S.: *On Hospitals.* New York, The Macmillan Co., 1947.

Dr. Goldwater's stimulating thoughts on the hospital and doctor can scarcely be overlooked as a basic wellspring of ideas regarding medical staff functions and organization and the place of the specialist in the modern hospital.

Hayt, Emanuel and Lillian R., and Groeschel, August H.: *Law of Hospital, Physician and Patient.* New York, Hospital Textbook Co., 1952.

A basic reference on all aspects of hospital activity and their legal implications, which also contains a treatment of medical staff relations, organization, and problems.

MacEachern, Malcolm T.: *Hospital Organization and Management.* Chicago, The Physicians Record Co., 1946.

An all-inclusive reference with an especially notable treatment of medical staff organization.

McGibony, John R.: *Principles of Hospital Administration.* New York, G. P. Putnam's Sons, 1952.

Chapter seven contains some specific recommendations, based on well established principles, for medical staff organization and practices.

Sloan, Raymond P.: *This Hospital Business of Ours.* New York, G. P. Putnam's Sons, 1952.

Chapters IX and X of this highly readable guide for trustees deal with "Matters of Medical Concern" and "Medical-Staff Relationships."

Most of the above books list extensive bibliographies on all aspects of medical staff organization and problems. Hence it does not appear too useful to relist such references in this column. However, particular attention should be given to some works outlining the role of the general practitioner in the hospital. The best reference is the *Manual on the Establishment and Operation of a Department of General Practice in Hospitals,* published by the American Academy of General Practice, Broadway and 34th Street, Kansas City 2, Missouri. There is a good article on the "Integration of the General Practitioner in the Hospital Medical Staff Organization" in the *Journal of the AMA,* 135:648-649, 1947.

In fact, the AMA has several reprints on the role of the general practitioner and medical education in hospitals, and several other basic subjects pertaining to the medical staff in the hospital. These can be obtained by writing to the Council on Medical Education and Hospitals, AMA, 535 North Dearborn Street, Chicago 10, Ill.

One can hardly talk about medical staff organization and practices without eventually broaching the subject of medical audits. High quality patient care is the keystone of a hospital's existence and yet how does one measure it? Some device is needed. A recent discussion of what one eastern hospital did to appraise its staff's performances is "The Medical Audit Gives the Answer" by A. W. Smith (*The Modern Hospital,* March 1953). Another illuminating summary is the report entitled "Effectiveness of Hospital Tissue Committee in Raising Surgical Standards" by Henry V. Weinert, M.D., and Robert Brill, M.D., presented in the November 8, 1952, issue of *The Journal of the AMA.* This same article also appeared in the December 1952 issues of *Hospital Progress* and *The Modern Hospital.*

● In a column of this nature it does not appear inappropriate to call attention to a recent pocket-size book on the rewards of reading, *The Wonderful World of Books.* The New American Library (Mentor Books) has cooperated with about a dozen voluntary and government organizations in making this non-profit title available to the public.

Practical suggestions are given on how to improve reading skill and get the most out of printed material when handicapped by the problem of lack of time so common to executives and professional people. And, best of all, it offers some recommendations on what to read. Today, all of us are barraged with a continual flow of words —some are good, but more are mediocre or bad—so that expert guidance is becoming a necessity.

All of the articles are short, so you can peruse whatever catches your fancy at the moment. The next time you are looking for some easy but informative reading to while away a few hours on a train or plane, pick up a copy at a newsstand.

● Readers interested in the general problems of health and medical care will treasure Dr. S. J. Axelrod's contribution on "The Medical Care Bookshelf." This appeared in the April 1953 issue of the *American Journal of Public Health.* Dr. Axelrod has done a noteworthy job in tying together the many references in this rapidly growing area of interest. And, it is highly readable. It will undoubtedly be a basic reference for a long time.

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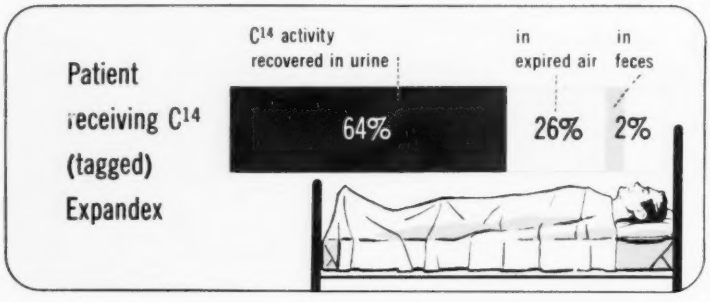
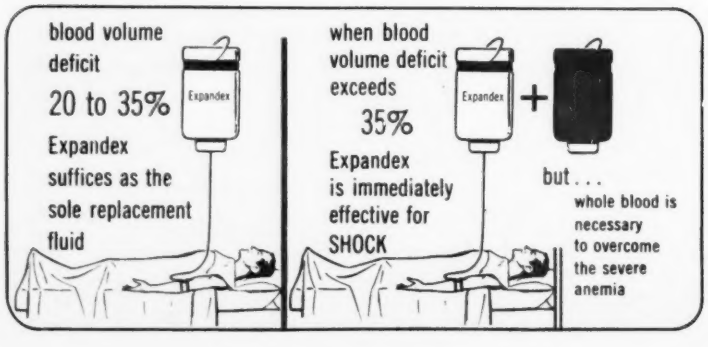




Chemistry

Expandex (Dextran) Injection, 6% is a sterile, nonpyrogenic 6% (w/v) solution of partially hydrolyzed dextran in isotonic sodium chloride solution. Dextran itself is a water soluble, high molecular weight polymer of glucose, which is produced by the action of the nonpathogenic organism *Leuconostoc mesenteroides* on sucrose. Dextran is closely related to glycogen; both these polysaccharides are made up of glucose units joined by similar linkages.

Pharmacology

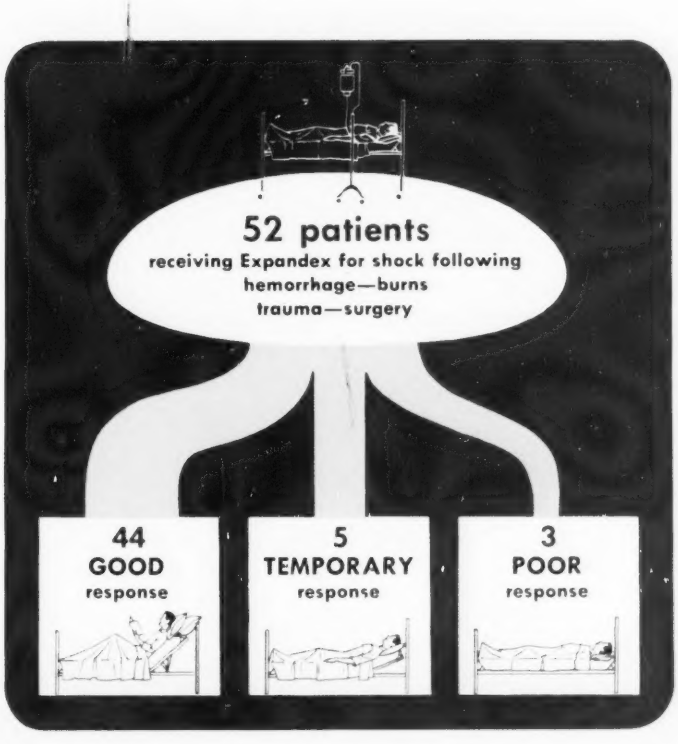
Given by intravenous infusion, Expandex is an efficient plasma volume expander.[1] As such it produces hemodilution manifested by a decrease in hematocrit and in total protein concentration. A 10% to 15% increase in plasma volume is produced by an infusion of 500 cc. of Expandex, while a 15% to 20% increase is produced by 1,000 cc. In normal individuals, Expandex has no influence on pulse rate, respiration, blood pressure, or ECG. No toxic effect has ever been demonstrated on kidneys, liver, and other vital organs.[2,3,4] Expandex does not interfere with blood typing, crossmatching, or Rh determination.

Fate

Virtually all injected Expandex can be accounted for through the experimental use of C^{14}-tagged dextran.[5,6,7] From 20% to 40% is excreted in the urine in the first 24 hours; the total urinary excretion of C^{14} activity is 65 to 75%. The bulk of the remaining radioactivity is recoverable in the expired air, indicating metabolism of dextran by the organism. About 2% is found in the feces.

Clinical Results

Expandex has been used with excellent results in all types of shock associated with a decrease in effective circulatory volume.[8,9] The plasma volume expansion it produces is maintained for periods sufficiently long to enable the circulatory system to overcome the altered dynamic state. In a typical series,[10] 52 patients in shock were given Expandex. Of these, 44 showed a good response, 5 a temporary response, and only 3 a poor response. Since it is sterile, Expandex does not carry, nor can it transmit, the virus of infectious hepatitis.



Indications and Dosage

Expandex is indicated in the treatment of shock caused by hemorrhage, burns, trauma and surgery. It can serve as the sole replacement fluid in hemorrhage when the blood deficit does not exceed 35%.[10]

Expandex is given by intravenous infusion; the average dose is 1 or 2 units (500 cc. or 1,000 cc.). A larger quantity safely may be given if required.

Clinical Advantages of Expandex®

1. It is a clinically effective and notably safe plasma volume expander, indicated in the prevention and treatment of shock due to hemorrhage, burns, trauma and surgery.
2. It is slowly metabolized and excreted.
3. It does not carry and therefore cannot transmit the virus of hepatitis.
4. It does not interfere with the functional activity of any organ or tissue in the body.
5. It does not interfere with blood typing procedures or crossmatching.
6. It is a nonpyrogenic and sterile solution.
7. It is fluid over a wide range of temperatures and is ready for immediate use.

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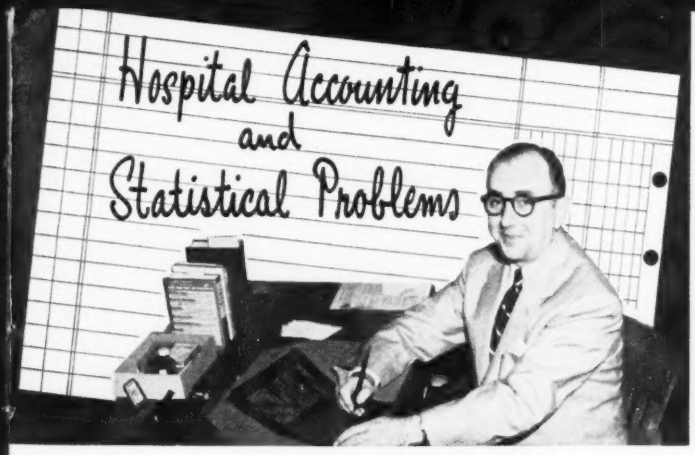


By David H. Tarlow, C.P.A.

Q. We sometimes pay the fees and give meals to special nurses who are needed for indigent patients. Should this be charged to allowances, nursing expense, dietary expense, or what? J. R. A., Chicago

A. It would appear that you have two elements of expense to consider in the foregoing statement. First, the payment to special nurses could best be reflected in an account called "Special Nurses Fees." We suggest this segregation from regular nurses on the payroll so that budgetary comparisons will not be distorted and that this information will be available for administrative guidance in cost analysis and public relations. Second, with respect to meals served special nurses, we suggest that you keep a separate meal count in the statistics of meals served. At the close of any accounting period you can determine this cost to the hospital by multiplying the meals served in this category by the average cost per meal.

Q. We have a 75-bed hospital. One of our board members has suggested that it might be cheaper for us to employ the services of a commercial laundry. In order to make an accurate comparison he requested that we advise him how much it cost us to clean and finish laundry per pound. We do not have a cost accounting system in our institution. Under these circumstances, can you tell us the best way to obtain the information? A.J.M., Philadelphia

A. Cost data contains elements of both direct and indirect expenses. Direct expenses, such as salaries of laundry employees, supplies, repairs, and maintenance can be obtained from your books of account. For an indirect expense such as electricity, I suggest that you gauge the cost of electricity by running it through a separate meter if possible. If this is too costly, the utility company might estimate the cost for you. If your institution is charged for water you can pro-rate the amount used without too much difficulty.

Housekeeping duties in the laundry are performed by personnel in the laundry department: so you do not have to apportion any expense from housekeeping for this service. A problem of dietary expenses arises if meals are served to employees in addition to their salaries. It will be necessary for you to add the cost of meals served to the operating costs of the laundry. In like manner, if any laundry personnel are furnished rooming facilities, another allowance should be added to cost of laundry expense covering the number of employees living in. In considering administrative expenses, I suggest using the excellent formula used by the United Hospital Fund of New York which distributes administrative overhead on the ratio of departmental salaries to total salaries. This procedure, while a bit lengthy, will give you the total cost of cleaning laundry at your institution. It should be noted that these expenses do not include the cost of new linen or linen room salaries. Keep a daily record of pounds of soiled linen cleaned and divide the total poundage into the cost to obtain the cost per pound. This should enable your board to make the comparisons they desire with commercial laundries.

Q. We are setting up a cost analysis system in our hospital of 300 beds. There is a difference of opinion as to how insurance expense should be distributed. Can you give us any suggestions? B.L., Philadelphia

A. In a hospital of over 300 beds it sometimes is expedient and more accurate to distribute insurance expense on an individual basis as follows:

Fire Insurance—Building on the basis of floor area, contents on a departmental basis.

Compensation Insurance—By an analysis of the payroll, charging the respective departments in ratio to total expense.

Public Liability—By ratio of patients admitted.

Boiler Insurance—Direct of Plant Maintenance.

Malpractice Insurance—Ratio of patient days.

Q. Inventory valuation poses a problem with us each year. It has been suggested that we change our valuing method from the lower of cost or market to the LIFO method. Would you recommend this for hospital accounting? S.T., Boston

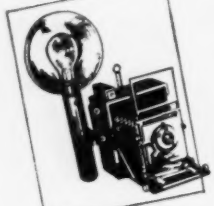
A. The "last in-first out" method (LIFO) is used in some instances in commercial accounting. It comes about by reason of the fact that where bins are kept for particular items, such as small machine parts, tools, etc., the last quantity placed in the bin will be the first quantity taken out. As a result unless you used the whole cost as a basis, you would not give proper effect to the withdrawal of current items. However, I would suggest that, where possible, the hospital would find it more expeditious and satisfactory to use the lower of cost or market in evaluating inventory.

Q. We received bids from contracting firms for an extensive alteration to our laundry building. After analysis it was determined that we could do the capital alterations ourselves at a great savings. What objection, if any, do you have to charging this improvement with the lowest contract price and crediting the difference to a Profit and Loss account? J.S., San Francisco

A. In using your own labor and materials, and thus securing the addition and alteration at less than the lowest contract price from an outside agency, the hospital has made a saving and not a profit. It would appear that this would preclude the possibility of crediting the Profit and Loss account since no profit has been earned.

During the life of the asset (alterations and additions) it is likely that the saving will become a realized profit. Cost of services rendered will be decreased because less depreciation will be charged in ensuing accounting periods, due to the lower cost value of the asset. Under normal conditions your charges or rates to patients would not be influenced by the total cost of this new construction, and the lower cost of rendering the services will provide a greater margin. All other conditions being equal, a greater net profit will thereby accrue to the hospital.

If you have a problem on hospital accounting or statistics send it to us and we will do our best to answer it in these columns.



Hospital Topics ..... Goes Calling

on John Garrison, Director
Los Alamos Medical Center
Los Alamos, New Mexico

John Garrison (l.), at the reception desk with Mrs. Gordon S. Erickson and Charles T. (Mike) Murphy, assistant administrator.

Story and photographs by Gordon M. Marshall

● A $2,750,000 medical center stands today on what was —less than 10 years ago—only the mountainous site of a private boys' school. Then, staff, students, and supplies went in by pack train in the fall, and they were isolated until spring. Today, 13,000 people live in this community which has grown up around the government's atomic energy laboratories, and the medical center is a vital part of community life.

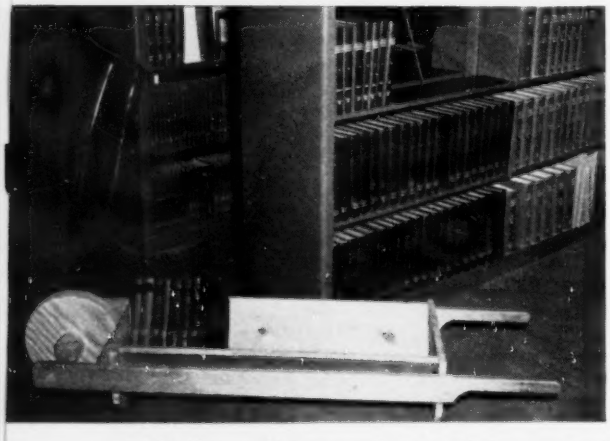
The 150-bed center has nothing but the best. Yet it was so well planned by Administrator John Garrison and his co-workers that there is no waste space or equipment. When the hospital was moved, ward by ward, from its old quarters into the center last year, it took only four days, thanks to careful planning.

In contrast to the strict regulations surrounding this government area was Mr. Garrison's friendly reception. He went to great lengths to show his domain, unlocking and locking doors so that TOPICS could present this picture story.

Mr. Garrison's theory of management can be summed up in his own words—"I believe in getting the best department heads I can and then leaving them alone. If they don't make the grade they don't stay, but I don't watch them every five minutes."

Although department heads are more or less on their own, Mr. Garrison maintains an open-door policy. He can be easily approached on departmental problems and is always ready to devote special time to coaching staff members on the necessary requirements for a promotion. He believes that everyone in the field has an obligation to help others, just as he is aided from time to time.

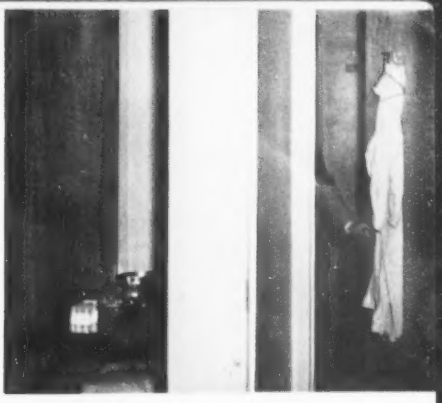
Above: General view of the clinical laboratory showing the circular staircase which leads to the laboratory work and storerooms. Supplies can be brought up by dumb waiter seen on the left. This arrangement is also found in the medical records department and the pharmacy.



In the library, which is complete enough for a medical school, books are transported with the homemade cart pictured here.

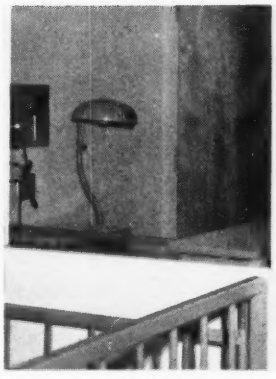
Right: One of Mr. Garrison's ideas on basic construction — to have access doors behind all built-in equipment. Dora G. Bustos, central supply supervisor, is shown with Mr. Garrison at the doors which give ready access to equipment. Mr. Garrison's head engineer was on the job during construction, so location of all pipes and similar valuable data are known to him.

Above: X-ray technician, Mrs. Christian, holds an x-ray plate on which the hospital's name has been etched. This practice eliminates any question in the future as to whether the x-ray was taken at the medical center. The patient's name and the date are listed below.



Above: An interesting and practical arrangement in the fluoroscopy department. The main door to the hallway and the access door to the patient's dressing room have locks controlled by a solenoid switch so that during fluoroscopy time or just previously, when the radiologist's eyes are becoming accustomed to the dark, no one can enter from the corridor unless the switch, located with the light switch, is thrown.

Above: Mrs. Fred Liederbach, R.N., is shown at the homemade wooden tray, which runs the width of the window sill and can be used to conveniently store necessary supplies at hand.



Left: Mrs. Annie Boyd, a nurse's aide, posed for us in the pediatric section. The room is so constructed that it may be used for rooming-in or that, in an emergency, two full beds can be used.

Right: Mr. Garrison's broad-shouldered figure and easy manner hide a restless energy which leaves nothing undone and which leads to constant improvement on existing conditions. Example: Maintenance morale received a boost and efficiency improved when wooden steps shown at the left were added on the delivery platform next to the trash dump boxes, eliminating the effort in wrestling galvanized cans from the floor to the top opening.

(Continued on next page)

Above: The axiom, "A place for everything and everything in its place," is certainly upheld in the fracture room. In addition to the customary plaster sink, operating light, and Bell table, all accessories are stored in the wooden cabinet built into one corner by the hospital carpenter.

Below: Mr. Garrison and Mr. Murphy have a discussion with Mrs. Hazel Yarnell, who was recently promoted to supervisor of the medical and surgical floors. The traffic flow on all incoming supplies is kept in a direct line from the receiving platform through the scales to this central storeroom, which is kept locked at all times. From here supplies are checked out to the cafeteria and food commissary just beyond and to the laboratory and the pharmacy storeroom and other hospital departments.

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*Clinical reports available

Above: Even more than in the average community, the hospital is a focal point in Los Alamos life. Mr. and Mrs. Garrison arrange to buy some Girl Scout cookies from Brownie Marianna Garcia, in front of the women's auxiliary lobby shop. Here, as in every room, the carefully selected and decorative draperies can be drawn across the picture window, softening the brilliant New Mexico sunlight.

THE LAB

A regular feature for Medical Technologists

M.T.s Have Section in New England Assembly

● *For the first time in the 30 years that the New England Hospital Assembly has been functioning, a sectional meeting in medical technology was added to the program. Here are abstracts of papers presented at the meeting.*

An Administrator Views Medical Technology

Gerald F. Houser, M.D., Director, Faulkner Hospital, Boston—With the scarcity of medical technologists it is necessary to adopt some expedient such as on-the-job training. But this is still not the answer. It is my conviction that if more good schools were established in good hospitals, well qualified to give proper teaching, there would be no lack of students. Let me stress, however, that you must be willing to pay a good salary to make the laboratory position attractive. Medical technologists are underpaid as compared to other lines of endeavor with similar or even lesser educational qualifications.

The present state of affairs cannot be tolerated. We must educate the doctors, the administrator, the trustees, and the public so that they realize the gravity of the problem and do something about it. It is the quality of the laboratory that counts. It is the duty of the administrator to keep a close watch on work of the laboratory. The correction of mistakes and the exercise of administrative control in the clinical fields is perhaps the hospital administrator's greatest test of ability. He must exercise the utmost in tactfulness and be sure that corrective measures are carried on.

Pathologist Looks at Medical Technology

Ralph E. Miller, M.D., Pathologist, Mary Hitchcock Memorial Hospital, Hanover, N. H.—It is my experience that the more training a medical technologist has in basic science and biology before beginning special training, the better technologist she becomes. An acceptable compromise is three years college combined with a year of training in high quality schools of medical technology.

Increasing requirements above a college education appears impractical because only a small number of people can afford the additional expense. Reducing the requirements below the two year minimum defeats our purpose.

The present training program is a product of many years study. The Registry reports that about 20,000 medical technologists have gained acceptance based upon standards which cannot be greatly modified.

Local conditions dictate different opinions. Solutions to local problems will not contribute much to general needs unless the local solution also meets a set of standards. The experience of certifying boards and schools of medical technology indicates that there should be a single standard of training in approved schools and a single standard of certification of graduates.

Small Hospital Has a Staffing Problem

Charles W. Capron, Administrator, Kerbs Memorial Hospital, St. Albans, Vt.—Small community hospital laboratories can afford to maintain a laboratory staff of three or four college trained technicians if they are fortunate enough to obtain them. The small hospital, however, faces the problem of staffing its unit. The solution to this problem may be found in one of the following:

1. Continuance of training and graduating college-degree technicians who can meet requirements of ASCP.
2. Use of graduates from 12-18 month courses conducted by approved schools and hospitals. This type of technician would provide staff members who are reasonably well qualified and capable under proper supervision.
3. Use of technicians trained only in our own laboratories. They should be taught by a college-trained technician. After 12-18 months training they are expected to do routine tests under proper supervision.

In addition to meeting the shortage these methods bring cost of staffing into reasonable line and produce high standards in laboratory work.

(Continued on next page)

Below: Inspecting a diagram of the new laboratory under construction at St. Elizabeth Hospital, Brighton, Mass., are, l. to r.: Mrs. Elinor Judd, M.T., ASCP, Robert B. Brigham Hospital, Boston; E. Howard Moss, M.T., ASCP, Hale Hospital, Haverhill, Mass., president, Massachusetts Association of Medical Technologists, and Mrs. Irene De Herrero, M.T., ASCP, Leonard Morse Hospital, Natick, Mass. The diagram was part of the Massachusetts Association's exhibit at the New England Hospital Assembly.

Members of the local committee, Ohio Society of Medical Technologists, shown at the society's banquet, are (l. to r.): Mary Kenkel, M.T., VA Hospital, Fort Thomas, Ky.; Edith M. Connolly, M.T., Dr. Jolson's Laboratory, Covington, Ky.; Mary A. Goerl, M.T., Good Samaritan Hospital, Cincinnati; Ruth Bluemlein, M.T., Campbell County Laboratory, Fort Wright, Ky.; Bessie Keating, M.T., Wright-Patterson AFB; William Syring, American Hospital Supply Corp.; and Mary P. Gauvey, M.T., Wright-Patterson AFB.

M.T.s in the News

Leaders in Ohio organizations are (l. to r.): Mary P. Gauvey, M.T., Wright-Patterson AFB, immediate past president, Ohio Society of Medical Technologists; Jane Taylor, M.T., Children's Hospital, Columbus, president-elect, Ohio Society; Mary Kenkel, M.T., VA Hospital, Fort Thomas, Ky., executive secretary, Ohio Society; and Edith M. Connolly, M.T., Dr. Jolson's Laboratory, Covington, Ky., president, Greater Cincinnati Society of Medical Technologists.

The American Society of Medical Technologists and the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists co-sponsored an exhibit at the meeting of the American Personnel and Guidance Association in Chicago. Shown at the exhibit are (l. to r.): William Busacker, director, Herkimer County Vocational Education and Extension Board, Salisbury Center, N. Y.; Mrs. Ruth Drummond, registrar, Registry of Medical Technologists, Muncie, Ind.; Beatrice Gerritsen, M. T. (ASCP), supervising technician, Evangelical Hospital, Chicago; and Norman P. Berdan, director, Montgomery County Vocational Education and Extension Board, Canajoharie (N. Y.) Central School. TOPICS Photos.

BUYER'S GUIDE

. . . items of interest for the hospital staff. For full manufacturer's information on products, write to the Buyer's Guide Editor, HOSPITAL TOPICS, 30 W. Washington St., Chicago 2, Ill., or use the handy postpaid reply card facing page 52.

100. Nipple Cap

Orchard Nipple Cap is made with a special, waterproof glue that enables it to withstand the rigors of terminal sterilization. Made of fine, white kraft paper with smooth glazed finish on the inside. Cap has convenient space for date, name, nursery, formula. Orchard Paper Company.

101. Conductive Wax

Swiftsheen Conductive, says the manufacturer, eliminates the dangers of dust or vapor explosions resulting from static electricity. Meets government safety requirements for a conductive non-sparking flooring surface. Easily applied, bright drying and non-slippery. The Gerson-Stewart Corp.

102. Massage Lotion

Lotocreme, new soothing, non-greasy body rub gives a mild, cooling sensation to the body and leaves the skin with a clean, refreshed feeling. White, stable oil-in-water perfumed emulsion contains 1.7 percent alcohol plus lanolin, olive oil, glycerin, and methol. Lotocreme is so well absorbed that it will not stain clothing or bed linen. Abbott Laboratories.

103. Nursing Station Imprinter

Information about an individual person or item is recorded in a self-writing Addressograph plate. One operation prints complete information—speedily, legibly, uniformly, accurately. Suited to operation in any location where records are written. Addressograph-Multigraph Corp.

1074. Melmac Orthopedic Casts

Orthopedic casts made with this plastic powder are thin and lightweight, but comparable in strength to casts that are two-thirds heavier. Melmac casts provide adequate immobility and support within a few hours of application. Thinness of cast permits greater x-ray penetration. Water and urine-resistant. Davis & Geck, Inc.

(Continued on next page)

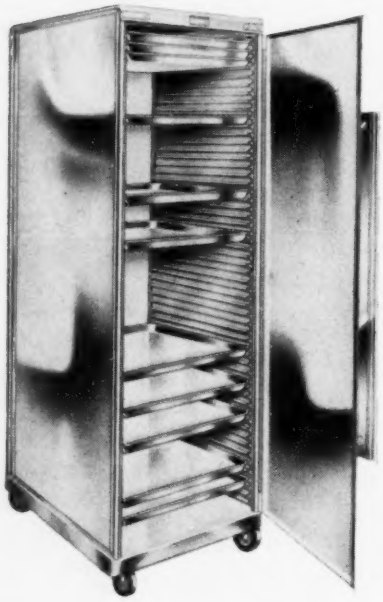
Jill Feldkamp and Don Klein, both of Addressograph-Multigraph, demonstrate the Nursing Station Imprinter (Buyer's Guide 103), during the Mid-West Hospital Association Convention.

Hal Perrin, administrator, Bishop Clarkson Memorial Hospital, Omaha, Neb., Bruce McWilliams, Edward J. Marlotte, both of Davis & Geck, and Charles D. D'Spain, administrator, Cody (Wyo.) Hospital, discuss the properties of Melmac Orthopedic Composition (Buyer's Guide 1074) during the Mid-West Hospital Association Convention.

BUYER'S GUIDE

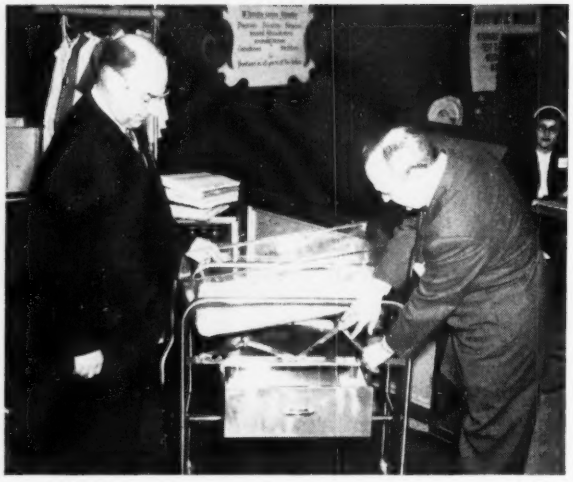
108. Artificial Leg

Suction Socket Leg, for below the knee amputations, designed for comfort by eliminating all circulation restricting straps. Soft cushion back adds to suction and encourages shrunken calf to redevelop. Socket is ventilated so that stump can receive air. The Emmett Blevens Co.



1247. Food Cabinet

Transitray is designed to meet the requirements of the most strict health departments. Its smooth aluminum alloy walls are easily cleaned. Featured is a patented fingertip slide control that lifts the latch to open the door. Unit rolls easily on double ball-bearing, rubber caster wheels. Deep - ribbed interior provides 48 sturdy tray guides. Bevles Co.



At the Tri-State Hospital Assembly, Omer B. Maphis, administrator, Greene Memorial Hospital, Xenia, Ohio, stops to examine a new bassinet (Buyer's Guide 105) shown by Michael Fischer, Debs Hospital Supply.

104. X-Ray Hanger

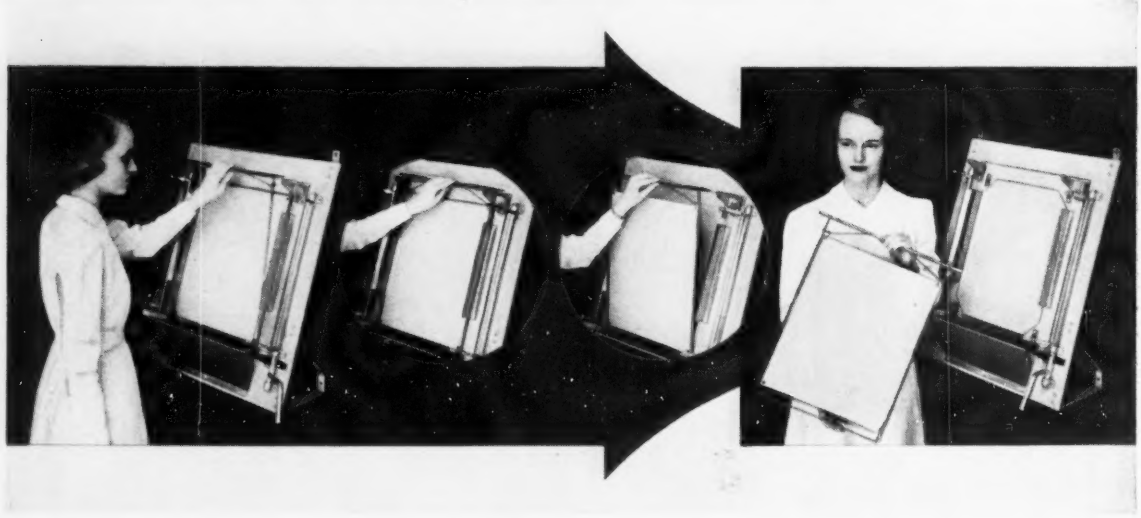
New x-ray film hanger and a semi-automatic loader board punches the film and then guides the film hanger to instantly pick up the film. Provides a fast, positive means of fastening exposed x-ray films to hangers in total darkness. Board is designed to be mounted on the wall or a very narrow shelf. Hard & Co., Inc.

105. Individual Care Bassinet

Plastic bassinet in stainless steel frame. Drawer holds items for maintaining care of individual infant—eliminates danger of cross infection. Debs Hospital Supply.

106. Thermos Vacuum Bedside Pitcher

Unit consists of pitcher, tray, and tumbler. Pitcher can be used for hot or cold beverages. Available in five pastel colors. Low-priced. Harold Supply Corp.



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☐	991 Air-Refresher	☐	111 K-2 and K-2R	☐	131 Laboratory Instruments
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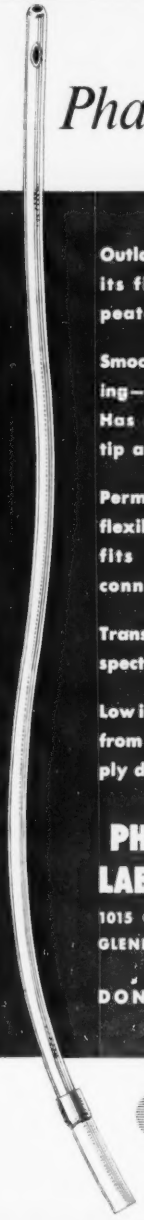

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Tomac Conductive Sole Shoes provide the vital protective link between personnel and the conductive floors upon which they stand. They are made by International Shoe Company and distributed by AMERICAN to hospitals throughout the country. May we send you the complete details?

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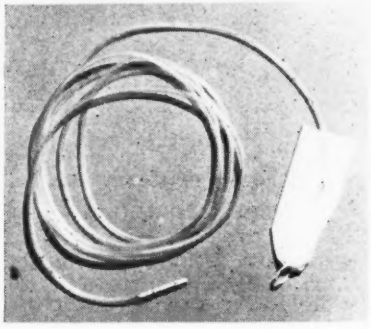
123. Cast Spreaders

Designed with thin, inter-digitated teeth which can be inserted into narrow saw slot made by the electric cast cutter. Teeth are made of a special alloy steel properly hardened to prevent breaking or bending. Rounded nose behind teeth prevents the blade from advancing into the plaster and pinching the skin. Available in two sizes. Orthopedic Frame Co.



111. Gastrointestinal Tubes

Patient discomfort is reduced to a minimum by the satin-smooth plastic tubing of the Pharmaseal Kaslow gastrointestinal tubes. The K-2 is transparent, the K-2R is radiopaque. Tubing is tasteless and odorless. Economical. Pharmaseal Laboratories.

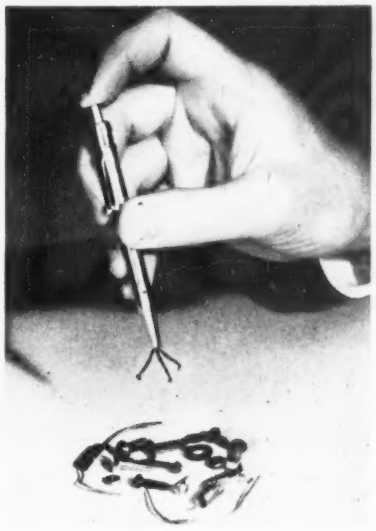
107. Plastic Place Mats

Vinyl mats are washable. Linen finish. Chartreuse, white, yellow, and salmon. Harold Supply Corp.

109. Surgical Pump

Herb-Mueller ether-vapor-vacuum apparatus keeps the patient constantly anesthesized with an even uninterrupted flow of controlled ether vapor. Simultaneously it maintains a powerful vacuum for drawing off blood, mucous, and pus from the operative field, minimizing the need for sponges and expediting the work of the surgeon. Explosive-proof. UL approved. V. Mueller & Co.

R. G. Fritschel, assistant superintendent, Milwaukee (Wis.) Hospital, and Leon R. Wheeler, Blue Cross, Milwaukee, get the details on the new Herb-Mueller Ether-Vapor and Vacuum Apparatus (Buyer's Guide 109) from Richard Meyers, V. Mueller & Co., during the Tri-State meeting.



112. Automatic Tweezer

Depressing the top plunger causes three strong, hooked spring steel fingers to extend from the tip and flare out. Releasing the plunger causes them to withdraw towards the tip and close together. Can be used to pick up hot or sterile objects. Made of stainless steel, can be sterilized by steam or boiling. Win Sales Co.

122. Luminous Decals

One minute exposure to light, each day, causes these decals to glow for a minimum of ten hours. Can be used as printed warnings in dark places. Luminous Decals.

(Continued on next page)

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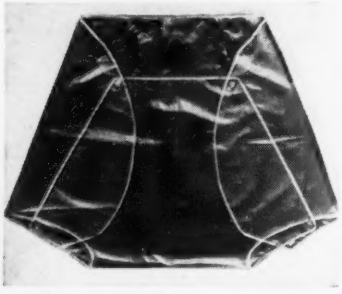
At the John Bunn Corp. exhibit, Tri-State Hospital Assembly, Glen F. Nonhof, Milwaukee, Wis., Marjorie Harsh, R.N., Clinic Hospital, Bluffton, Ind., and Hertha Wegner, technician, Memorial Hospital, Elmhurst, Ill., listen to P. M. Casady explain the Casady Syringe Cleaner. (Buyer's Guide 113.)

113. Casady Syringe Cleaner

Positively and forcibly cleans and rinses 156 syringes at one time. Accommodates all sizes from 1cc to 20cc. Uses hot solution, shuts off automatically, and operates by jet pressures, individually washing each syringe three times per second. The John Bunn Corp.

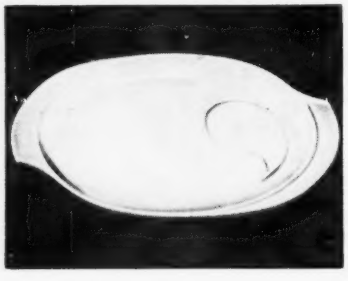


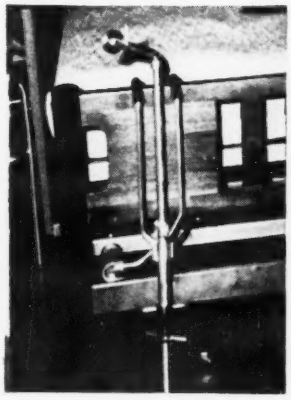
858. Protex-U

New Bakelite clear plastic garment for incontinents and postoperative cases. Eliminates discomfort, reduces odor. Adjustable at waist and thigh with simple nonslip and adjustable snap buckles. Cool, comfortable, and ventilated. Unfolds completely, no need to slip over feet of patient. Cuts cost, saves wear and tear on sheets. Can be autoclaved. Everest & Jennings.

1262. Platter

11-inch Boontonware platter allows a sandwich, salad, or pie and coffee to be served all on one unit. Reduces the number of dishes needed for small servings. Stacks simply and easily. Available in seven colors. Boonton Molding Co.



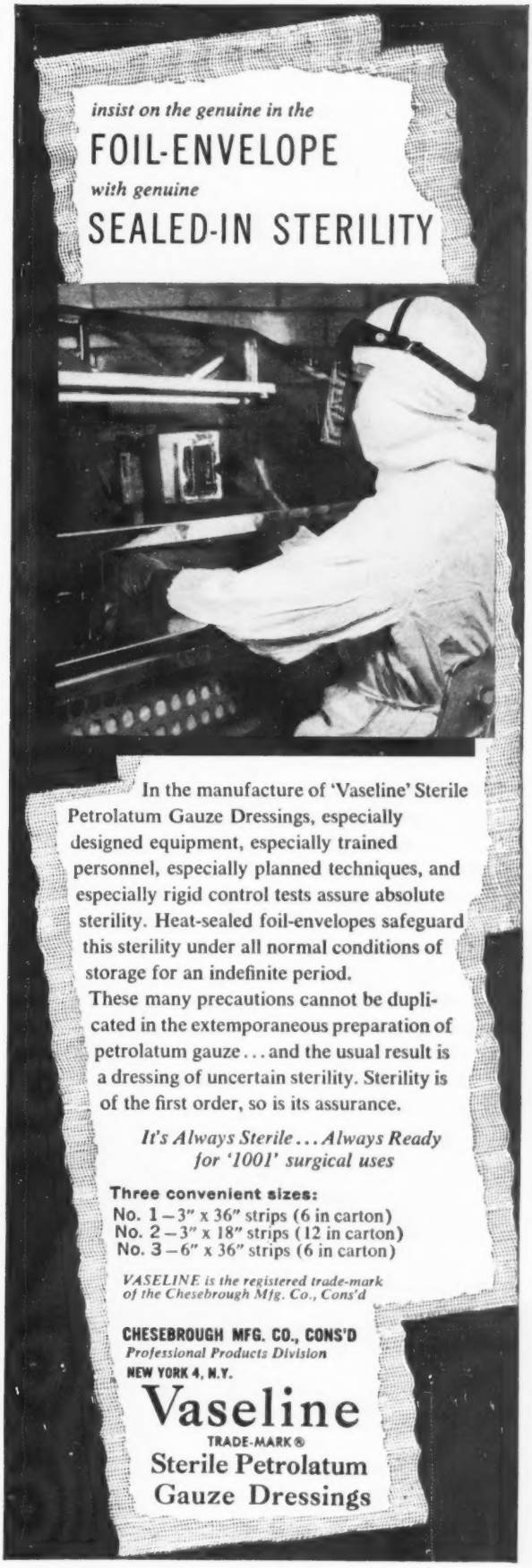


975. Traction Unit
Anybed Buck's Extension will fit on any bed, metal or wood. A quick method of applying traction to the lower extremities without the necessity of putting up a complete overhead frame. Can also be used with a complete overhead frame. Simple, easy to use, and with every adjustment. Gilbert Hyde Chick Co.

988. Standard Convalescing Pillow
Saves time in caring for patients. Convalescents using this pillow can remain in the same position for a longer period of time without tiring. By gradual elevation the body weight is kept off the arms and elbows. Helps prevent muscle strain. Pillow retains its shape even when in constant use. Standard Chemical Co.

(Continued on next page)

During the Association of Western Hospitals Convention, Ray Hausted (second from left) watches Fred Walsh, Sequoia Hospital, Redwood City, Calif., sign an order for a Hausted Wheel Stretcher. In the background, Mrs. Hausted demonstrates the stretcher to William Sanderson, who will be administrative resident at Sequoia Hospital starting June 1.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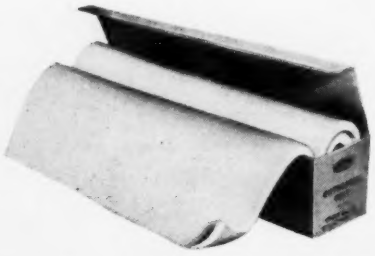
BUYER'S GUIDE

1140. Defibrillator

Eliminates shock hazard to surgeon and is simple to operate. Adjustable current intensity and automatic cycling prevent overtreatment through personal error. Requires a minimum of previous operator instruction. Coleman Instrument Co.



1257. Felt

For use in bandages, tourniquets, surgical splints, diathermy equipment, blood transfusion apparatus, etc. Felt is furnished in a corrugated, self-dispensing package which minimizes handling when cutting to desired length. Box keeps felt clean and is convenient as storage container. Felt is available in ¼- or ½-inch thicknesses. Professional Specialties, Inc.

115. New Dusting Aid

Exodust has an affinity for dust, and picks up and holds all the dust it touches. Dust cloths and dust mops should be saturated with Exodust and then allowed to dry. Several dusters may be treated at one time and laid away to be used as needed. Boots Corp.

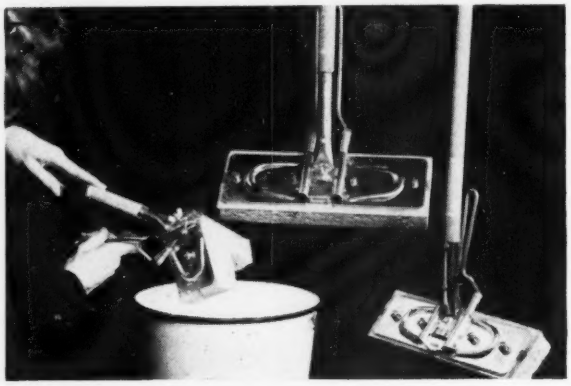
At the Mills Hospital Supply Co. exhibit, Tri-State Hospital Assembly, H. K. Weatherford explains the details of a new bassinet (Buyer's Guide 1240) to Kathy Neibaur, charge of central supply, St. Luke's Hospital, Racine, Wis., and Vivian E. McCullough, assistant director, nursing service, of the same hospital.

1240. Bassinet

Stainless steel bassinet designed to serve either rooming-in technic or cubicle nursery arrangement with maximum safety and facility. Lightweight construction and rubber-tired swivel casters aid mobility. Unit is equipped with an extra long extension base which slides under the bed, bringing all necessary supplies within the convenient reach of the mother. Mills Hospital Supply Co.

116. Bed Occupancy Monitor

New automatic signal device for the protection of bed-restricted hospital patients instantly alerts nurse when a patient is unduly active or attempts to leave his bed. Monitor is easily attached to any hospital bed and can be engineered to connect into the audio-visual nurse call system. Movement sets off chime and lights red lamp at the nurse's duty station. Executone, Inc.



117. Janitorial Moppers

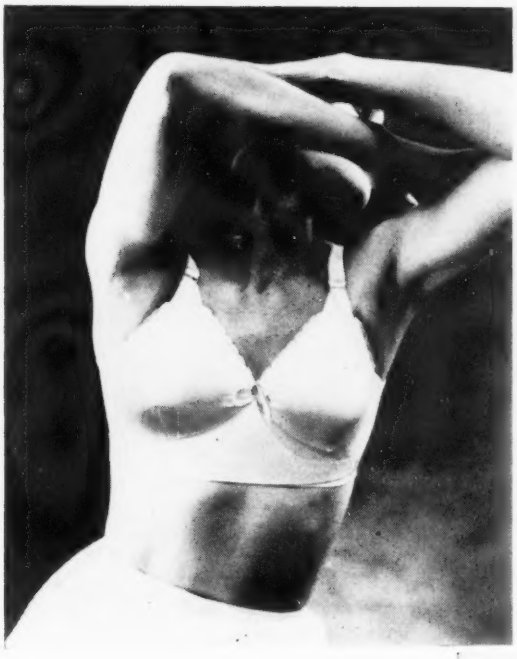
The Speedway is now available in three convenient sizes. The replaceable mop heads, made from Du Pont cellulose sponge, are on stainless steel hinges. When the wringing handle is pulled down, the sponge squeezes damp-dry against itself. Hancock Quickie Mop Co.

118. B-D Multifit Syringes

New syringe provides the convenience and economy of interchangeable parts, the performance of an individually fitted syringe, the durability of a clear glass molded barrel. Becton, Dickinson and Co.

991. Air-Refresher

Electronic odor-control fixture that destroys unpleasant odors, incorporates the new GE and Westinghouse Odor-out lamps, operates continuously at a cost of less than ½c per day. Has been proven effective for cancerous, burn, and other repugnant odors. May be employed in lavatories, operating rooms, kitchens, patients' rooms, and other areas where an odor persists. Midwest Fixture Co.



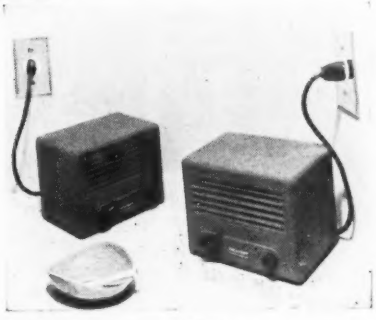
124. Nursing Bra

Double band around the bottom with Parva buckle at either side permits opening of band to take care of increasing size through the rib structure during pregnancy. Drawstring in the center front opens to allow a little more room in the cup. Elastic panels at the side of the bust cups give support to the breasts from the sides. Shoulder straps inner-lined with flannel prevent cutting. Pads available for nursing purposes. Fancee Free Manufacturing Company.

T. P. Comeford, inventor, demonstrates the new Contax Conductive Meter, shown for the first time at the Association of Western Hospitals Convention.

126. Alesen T-Tube

Disintegrating Alesen T-Tube for safer gastrectomy. Reduces hazard of duodenal stump disruption. Smoother post-operative convalescence. Tube disintegrates and is discharged in five to seven days post-operatively. Contains barium sulfate for x-ray purposes. Seal-Ins Labs.



125. Intercom Units

Two Standard Model CC-2 Vocatron "wire-less" portable intercom units need no connecting wiring. Units operate over the 110 volt lighting circuits already installed in the building, are light, compact, and easily carried from one outlet to another. Vocaline Co. of America, Inc.

120. Conductive Meter

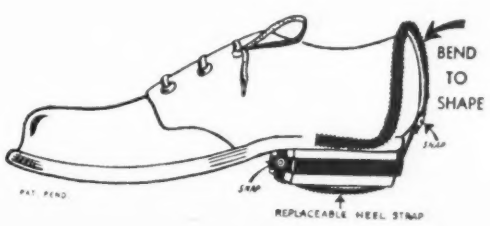
Contax Conductive meter is a precision instrument for accurately measuring the conductivity and ohm-resistance of all types of body-to-floor conductive sandals, footwear, and appliances. One simply steps on conductive plastic mat, touches handle at top of cabinet to register conductivity. Institutional Equipment Co.

127. Roach Spray

Pressurized container deposits an invisible film of active ingredients having both contact and residual killing powers. Spray forces killing ingredients directly into crevices, cracks, corners, etc. Quick and easy to use. Non-toxic to humans. J. I. Holcomb Research Laboratory.

119. Conductive Slipons

Conductivity lasts the life of the Slipon. Built with high conductivity so that they will not easily become insulated by ordinary surface dirt. Conductive Shoe Co.



121. Bloodpressure Cuff

Cleanable Air-Lok Cuff assures accurate, repeatable readings. Contains a built-in inflation bag, no separate rubber bag is required. Cuff can be wiped clean—or washed with soap and water before or after use. W. A. Baum Co., Inc.

(Continued)

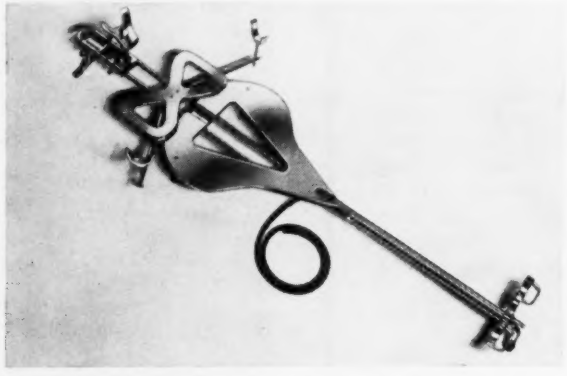
BUYER'S GUIDE

143. Floor Cleaner

New cleaner concentrate, DCD-35, is said to disinfect, clean, and deodorize in one operation. As a disinfectant, DCD-35 is said to contain no quaternary germicide, to retain its antiseptic power even when mixed with additional soaps, and to be effective on contact. If not rinsed, it continues its germicidal action long after application. James Good Company.

141. Autoclave Tape

F. O. S. High Temperature Tape for surgical packs withstands autoclaving without leaving gummy residue. Seamless Rubber Co.

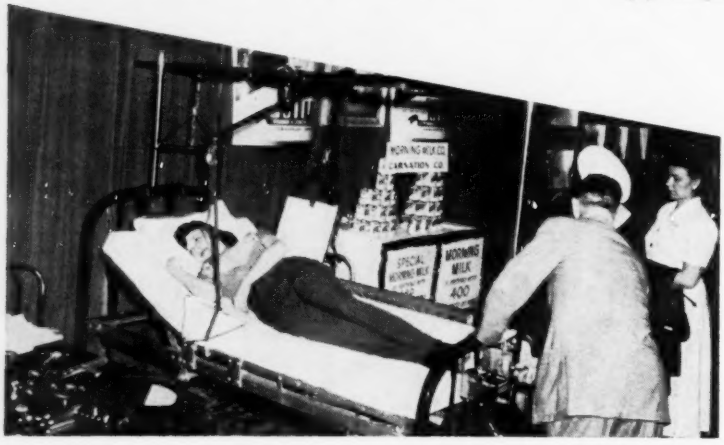


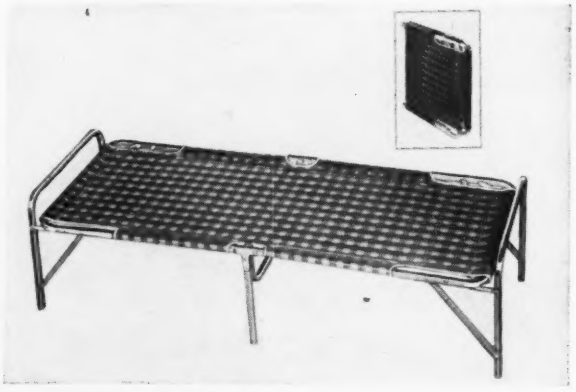
1246. New Type Autopsy Support

Hydra-Sana-Rest eliminates clumsy handling of body and makes autopsies quicker and cleaner. Holds body three inches above table for convenience in dissecting and drainage. Adjustable to any size body from infant to large adult—gives firm support at head, shoulders, arms, buttocks, and feet. American Hospital Supply Corp.

140. Glass Rack

36 compartment Sani-Stack Glass Rack with individually welded cells for each glass, offers protection against scratching and frosting which ordinarily occurs when glasses come in contact with each other. The manufacturer states that these racks reduce glass handling as much as 71 percent when used for transporting, washing, and storing glasses. Metropolitan Wire Goods Crop.





1248. All Purpose Folding Bed

Sturdily constructed of deluxe mirrorized, non-corrosive square aluminum tubing, for indoor and outdoor use. Comfortable, lightweight, easy to carry, easy to fold. Available in a variety of colorful Saran plastic covers which are waterproof, sunproof, and colorfast. U. S. Chaircraft Manufacturing Company.

142. Specimen Bottle

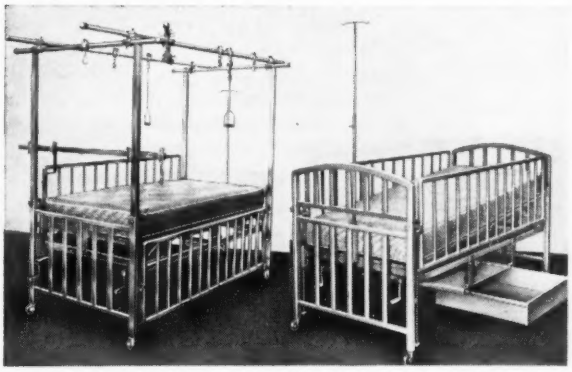
Disposable container for urine specimens. Made of heavy paper, wax-coated inside and out. Metal rims permits non-drip pouring, makes paper cap fit tightly. Cone-shaped bottle is virtually impossible to tip. American Hospital Supply Corporation.

1028. Fracture Frame

Plymale Hydraulic Fracture Frame lifts the heaviest patient with finger-tip pressure. Canvas sling bears weight of patient as frame is raised for bed pan use, linen change, etc. Can be used in open air treatment of burn cases and for getting a patient out of bed when flexing of the spine is counter-indicated. De Puy Mfg. Co.

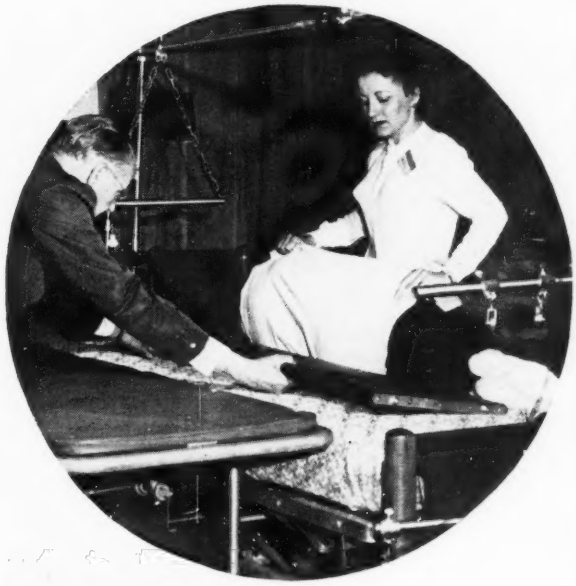
114. Germicidal Solution

Radiol Germicidal Solution depends on the anti-bacterial properties of the quaternary ammonium salts rather than the mercurials. These salts are less toxic than mercurials, should the solution be accidentally injected. The lower surface tension enables the solution to effectively cover the surfaces of the surgical instruments immersed in it. Novocol Chemical Mfg. Co., Inc.



149. General Utility Hospital Bed

Quickly converts for any emergency into: recovery bed, labor bed, fracture bed, eye bed, delivery bed, neurological bed, examination bed. No brackets or attachments—fittings built into this bed permit smooth, easy insertion and removal of parts such as head and foot, canopy rods and irrigation rods. Frank A. Hall & Sons.



147. Davis Patient Roller

Device for transfer of patient from bed to stretcher. Heaviest patient can be easily moved. Transfers are made safely as the bed and stretcher are temporarily locked together by the weight of the patient on the roller. Gilbert Hyde Chick Co.

(Continued on next page)

TWICE AS MANY RECORDS IN THE SAME AREA

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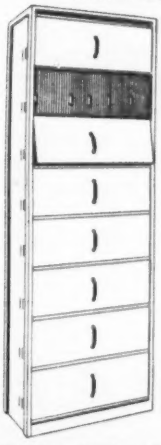

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NEW LITERATURE

133. Good Bleaching Practice Pointers—12-page booklet, a ready reference bulletin for laundrymen. Diamond Alkali Co.

132. How to Care for Your Floors—booklet contains three special sections: Practical hints that help cut upkeep costs, How to cure sick floors, and How to maintain floor safety. S. C. Johnson & Son, Inc.

130. Melmac Plastic Dinnerware—illustrated booklet describes the properties of Melmac Plastic, and how to properly wash and care for dinnerware made of this molding compound. American Cyanamid Co.

128. Light for Surgery — contains complete descriptions of modern surgical lights, including the new Surg-O-Beam. Shows a detailed sketch of the hanger assembly, recommended wiring diagrams, roughing-in data, and location plans. Ohio Chemical & Surgical Equipment Co.

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a proven, effective
plasma volume expander
Dextran (Hyland) is a safe and clinically effective plasma volume expander designed for the treatment and prevention of shock due to burns, hemorrhage, surgical procedures and other conditions. It is a sterile, nonpyrogenic 6% w/v solution of dextran in saline, prepared for intravenous infusion.
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129. Diagnostic Instruments—catalog and price list, includes Ophthalmoscope-Otoscope sets, E.E.N.T. accessories, body cavity instruments, etc. National Electric Instrument Co., Inc.

131. New catalog of laboratory instruments — including a new sample changer, new medical counting system, personnel monitoring systems, and other new equipment for detection and measurement of radioactivity. Nuclear-Chicago.

134. Chart Your Course Toward Dietetics — fact sheet designed for the junior high and high school student who is contemplating specialization in this field. The American Dietetic Association.

135. A Dietitic Interneship — for the college student who is considering the year's interneship. The American Dietitic Association.

136. Sterile Instruments for the Hospital — complete line of instrument sterilizers, concisely illustrated, described, and dimensioned in new catalog. Included are recommended layouts for central instrument preparation rooms, instrument clean-up room and sub-sterilizing facilities between Operating Rooms. American Sterilizer Co.

NEW FILMS

137. Oxygen Dosage and Technics—16mm. sound, color motion picture. Clinical conditions for which oxygen is frequently prescribed are reviewed. Concentrations of oxygen used to overcome or relieve anoxia are discussed. Linde Air Products Co.

138. Oxygen Therapy in Heart Disease—16mm. sound, black and white motion picture. The role of oxygen in the treatment of congestive heart failure and acute coronary occlusion is discussed. The accepted procedures and equipment used in administering oxygen therapy to such patients is demonstrated. Linde Air Products Company.

139. Oxygen Therapy Procedures — 16mm. sound, black and white motion picture. Illustrates the different types of apparatus by which oxygen can be administered and demonstrates correct operating procedures for each type of apparatus. Linde Air Products Company.

Personally Speaking

Joel Anderson — has resigned as business manager, Harris Hospital, Newport, Ark., to accept a position with the Arkansas Medical and Hospital Service, Little Rock.

William B. Barnhart — is now administrator, Maury County Hospital, Columbia, Tenn. He recently completed an administrative residency at Harrisburg (Pa.) Polyclinic Hospital and will receive a master's degree in hospital administration from Northwestern University.

Msgr. John W. Barrett—director of hospitals, Archdiocese of Chicago, has been appointed to the Joint Commission on Accreditation of Hospitals. He fills the vacancy created by the death of **Msgr. John J. Healy.**

George H. Berryman—has resigned as administrator, Washington County Hospital, Fayetteville, Ark.

Sister Mary Bertha—formerly administrator, SS. Mary and Elizabeth Hospital, Louisville, Ky., has succeeded **Sister Mary Benigna** as administrator, Our Lady of Peace Hospital, Louisville. Sister Mary Benigna has been assigned as consultant, St. Vincent Infirmary, Little Rock, Ark., for construction of a new hospital. New administrator of SS. Mary and Elizabeth Hospital is **Sister John Miriam**, formerly assistant administrator, St. Joseph Infirmary, Louisville.

Helene Brady—has resigned as dietitian, Uniontown (Pa.) Hospital, to accept a similar position at the Frick Memorial Hospital, Mt. Pleasant, Pa.

Above: Back on the job is Phillip G. Duffy, purchasing agent, Stanford University Institutions and Hospital, San Francisco, after a six months convalescence following a severe attack of polio. Mr. Duffy is shown in his office which was decorated in gala "welcome back" fashion by his staff.

James W. Brown, Jr.—is now administrator, Russell Hospital, Alexander City, Ala. He was formerly assistant superintendent, Grady Memorial Hospital, Atlanta, Ga.

Ray E. Brown — superintendent, University of Chicago Clinics, and **Leslie D. Reid**, superintendent, Presbyterian Hospital, Chicago, have been elected to the board of directors of the Welfare Council of Metropolitan Chicago.

Gertrude Caffrey — who has been acting superintendent, Carbondale (Pa.) General Hospital, since the resignation of **Herbert Keyser**, has been promoted to **superintendent.**

H. Z. Chalin—has been named administrator, West-Calcasieu Cameron Hospital, Sulphur, La. The hospital is scheduled to open about June 1.

Clyde Colvin—has succeeded **Dallas B. Reynolds, M.D.**, as administrator, Lallie Kemp Charity Hospital, Independence, La. Mr. Colvin previously was business manager, Ruston (La.) Tuberculosis Hospital.

Roy A. Colwell—has been appointed administrator, Memorial Hospital, Mattoon, Ill. Formerly a hospital administrator in Canada and in Jasper, Ala., Mr. Colwell will receive a master's degree in hospital administration from Northwestern University in June.

Thad F. Connally — has been employed as administrator, Mississippi County hospitals, Blytheville and Osceola, Ark. He was formerly administrator, Mary Washington Hospital, Fredricksburg, Va.

J. P. Cox—formerly administrator, Stillwater (Okla.) Municipal Hospital, is now administrator, Community Hospital, Paragould, Ark. He succeeds **Eugene Lopez**, whose resignation was announced in the February issue. Mr. Lopez is now with the Arkansas Medical and Hospital Service, Little Rock.

Myrtle Donahoo — assistant dietitian, Lincoln (Neb.) General Hospital, retired April 1 after 25 years of service.

Sister Mary Ellen — has been appointed director of nursing education, Mercy Hospital School of Nursing, Buffalo, N. Y. Succeeding to her former position as director of nursing, St. Jerome Hospital, Batavia, N. Y., is **Sister Mary Cyrila**, formerly at Kenmore Mercy Hospital, Buffalo.

(Continued on next page)

CLASSIFIED

POSITIONS OPEN

ADMINISTRATORS: (c) Lay; new general hospital 225 beds; around $15,000; one of most modern on west coast. (d) Lay; voluntary general hospital; 300 beds; around $18,000; excellent city; Midwest.

ADMINISTRATORS-NURSES: (a) Preferably nurse-anesthetist; new general hospital 40 beds; minimum $5,000; Michigan. (d) Voluntary, general hospital 50 beds; expansion program; $5,000; full maintenance; town 35,000; west mountain state.

ADMINISTRATIVE POSITIONS: (a) Personnel Director; teaching hospital 350 beds; around $5,000; large city; university medical center. Midwest.

DIETITIANS: (a) Chief; complete supervision; 90 employees in department; requires ADA; general voluntary hospital 300 beds; California; (c) Chief; 250 bed voluntary general hospital; around $450; city 50,000 near Toledo.

DIRECTOR OF NURSES: (a) Complete charge nursing service & education; requires degree; voluntary general hospital 150 beds; 25 students; $400 full maintenance including lovely quarters. Maryland. (b) Nursing & education; voluntary general hospital 500 beds; $6,000; East.

FACULTY APPOINTMENTS: (a) Educational director; full charge; voluntary general hospital; 300 beds; minimum B.S.; town 135,000 near 2 medical schools; $6,500; Central. (d) Instructor, science; preferably qualified in virology; teach medical students; opportunity research; $5,000; university school; large city; West. (e) Clinical instructor; two required; general voluntary hospital 200 beds; approved school; around $350; meals; lovely residential suburb near 2 medical schools. (f) Nursing arts instructor; collegiate school; NNAS approved; 100 students; position carries full faculty status; city 400,000; Pacific Coast.

HOUSEKEEPERS: (a) Executive; one of country's most important university hospitals; 1,000 beds; substantial salary.

RECORD LIBRARIANS: (a) Chief; registered; general voluntary hospital 600 beds; substantial salary; large city; university medical center.

POSITIONS WANTED

ADMINISTRATION: Medical; five years, assistant director, university hospital; six years, director, important medical center, 500 beds; chief consultant, national hospital organization; FACHA.

ADMINISTRATOR: Lay; three years, associate director, 750 bed university hospital; on faculty, university school of hospital administration; prefers smaller hospitals; draft exempt.

ADMINISTRATOR: Graduate Nurse; B.S., ten years, Director, 500 bed voluntary general hospital; well-experienced, public relations, fund raising; FACHA.

ANESTHESIOLOGIST: Diplomate, American Board, Anesthesiology; five years, director, department anesthesiology, important university hospital.

PATHOLOGIST: 32; 4F; Diplomate, (pathological anatomy, clinical pathology); trained important large hospital; three years, postgraduate, pathology, Mayo Foundation, well trained young pathologist.

RADIOLOGIST: Diplomate, (Therapy & Diagnosis); five years, professor, radiology, important medical school and director, department radiology, its 500 bed graduate hospital.

Additional Classified on pages 62 and 78

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PERSONNEL DIRECTOR: (a) Middle West. 200-bed general hospital in city of 75,000. Excellent opportunity for a young man with a good background in personnel work. $6,000.

BUSINESS MANAGER: Middle West. 250-bed general hospital. Requires good experience as business manager in a hospital of comparable size. $6,000 minimum to start.

CLINICAL PSYCHOLOGIST: Will conduct psychological examining of psychiatric patients, psychotherapy and research; also participate in the training of psychology interns. To $5,100.

DIETITIANS: (a) Chief. 150-bed general hospital, fully approved; all facilities complete and modern. $4,800 plus maintenance. (b) Assistant. East. 290-bed hospital, fully approved. Assist supervising dietitian in preparing and serving approximately 220 patients. $3,600. (c) Chief. South. New ultra modern 70-bed hospital located in beautiful resort area. Climate mild in winter; ideal in Spring, Summer and Fall. (d) Assistant. East. 150-bed county hospital; no nursing school. Supervise service of all foods for patients on special diets. $3,400 to start.

EXECUTIVE HOUSEKEEPERS: (a) South. New ultra modern 70-bed hospital located in beautiful resort area. Climate mild in Winter; ideal during other seasons. (b) Middle West. 110-bed general hospital; two buildings of sixty and fifty beds each. Excellent staff of competent workers. (c) East. Large teaching hospital; complete responsibility for department excepting the manufacture, repair and issuing of linens. (d) Middle West. 325-bed hospital located in large city; approximately 100 employees in department.

PHARMACISTS: (a) Assistant. Midwest. 250-bed general hospital, fully approved. Three in department. To $4,500. (b) Northwest. 800-bed general hospital, fully approved, 5 in department. $350-$400. (c) California. 200-bed general hospital; complete charge of department. $5,600. (d) Midwest. 325-bed hospital, 4 in department. Attractive summer resort location; to $4,500.

OCCUPATIONAL THERAPISTS: (a) Supervisor. Head department of 600-bed teaching hospital; facilities complete and modern; three employees in department. To $4,200. (b) Administrative; 28 employees in department. Well known institution for care of neuropsychiatric patients. Occupational therapy program is one of most outstanding in the world. To $4,500. (c) New, modern hospital with bed capacity of about 300, affiliated with well known university. This is an unusual opportunity.

PURCHASING AGENTS: (a) Midwest. 300-bed general hospital; $5,000. (b) Eastern medical center; comprising several hospitals. Full charge. $5,000 minimum. (c) Assistant. East. Medical purchasing experience not required. $3,500.

LAUNDRY MANAGERS: (a) East. Large hospital within commuting distance of Baltimore. $4,200. (b) Midwest. Large, approved teaching hospital. Thirty employees in department. Excellent opportunity for well qualified man.

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Additional classified on pages 61 and 78

PERSONALLY SPEAKING continued

Charles E. Frenzel—has been named administrator, Bedford County (Va.) Memorial Hospital. Plans for the 48-bed hospital are awaiting state and federal approval for Hill-Burton aid.

Ralph Friedlander, M.D. — is now director of surgery, Bronx (N. Y.) Hospital. Previously, he was chief of surgery, Brooklyn VA Hospital.

Mrs. Ned Gerber, R.N. — has resigned as superintendent of nurses, Dukes-Miami County Hospital, Peru, Ind.

Robert Gordon Gilbert, M.D. — is administrator and radiologist, Perry County Memorial Hospital, Tell City, Ind. Dr. Gilbert recently returned from service with the Navy.

Mrs. Joseph Gochnour, R.N. — has succeeded **Margaret Yanssens, R.N.,** as director of nurses, Bedford County (Pa.) Memorial Hospital. Mrs. Gochnour held the same position previously, until her resignation last winter.

Leonard P. Goudy—resigned as secretary, council on administrative practice, AHA, Chicago, to become administrator, John C. Proctor Memorial Hospital, Peoria, Ill. Before joining the AHA staff more than five years ago, Mr. Goudy was administrator, Saskatoon City Hospital, Saskatoon, Sask., Canada.

Mrs. Thomas E. Grossman, R.N.—has been appointed obstetrical supervisor, Methodist Hospital, Indianapolis, Ind. Mrs. Grossman was clinical instructor, Mt. Sinai Hospital School of Nursing, Cleveland.

Mrs. Hazel Hoffman, R.N.—assumes her duties as director of nurses, Union Hospital, Terre Haute, Ind., in June. **Ellen Church,** who has been acting administrator and director of the school of nursing since July, 1952, then will become administrator.

Frank L. Jennings, M.D.—has resigned as superintendent, Sunnyside Sanitarium, Indianapolis, Ind., effective July 1, to become chief of professional services, new VA Tuberculosis Hospital, Indianapolis.

J. Richard Johnson — formerly assistant administrator, Sherman Community Hospital, Elgin, Ill., has been employed as administrator, Sycamore (Ill.) Municipal Hospital.

John M. King—resigned as administrator, Petersburg (Va.) General Hospital, effective July 1. He plans to become a hospital consultant.

Thomas A. Larkin—is the new assistant administrator, Reading (Pa.) Hospital, succeeding **John A. Schaffer,** who is now administrator, Washington County Hospital, Hagerstown, Md. Mr. Larkin served his administrative residency at the Reading Hospital.

Paul Littrel — who has succeeded **Dale E. Keller** as business manager, Saunders County Community Hospital, Wahoo, Neb., formerly held a similar position at Municipal Hospital, Gordon, Neb. Mr. Keller's appointment as assistant business manager, Children's Memorial Hospital, Omaha, Neb., was announced in the February issue.

Mrs. Lora E. Matson, R.N. — has been named superintendent of nurses, Sid Peterson Memorial Hospital, Kerrville, Tex., succeeding **Ethel B. Stinson, R.N.,** who resigned.

Clarence Miller—has been appointed business manager, Loma Linda (Calif.) Sanitarium and Hospital. He succeeds **J. H. Nies,** who is now assistant controller, College of Medical Evangelists, Loma Linda. Mr. Miller formerly was manager of the patients' business office at the hospital.

The Rev. Clarence A. Morrill—has resigned as administrator, Holden

Hospital, Carbondale, Ill. **Mrs. Katherine D. Bilivar, R.N.**, superintendent of nurses, also resigned.

Kenneth W. Newman—assumes his duties June 1 as assistant administrator, Arkansas State Hospital, Little Rock, succeeding **A. C. Yopp**, who resigned to become assistant director of state institutions for Kansas. Mr. Newman was formerly administrator, University Hospital, Little Rock.

Leonard S. Nolan, M.D. — has resigned as superintendent, Eastern State Hospital, Lexington, Ky., effective June 1. His assistant, **Charles D. Feuss, Jr.**, becomes acting superintendent.

Lyda Nye, R.N.—is the new director of nurses, Clearfield (Pa.) Hospital. She succeeds **Priscilla K. Hall, R.N.**, who is retiring. Miss Nye has been a nursing arts instructor, Clearfield Hospital School of Nursing, since June, 1952.

Charles E. Price, M.D.—has resigned as medical director, Hahnemann Hospital, Philadelphia, effective June 30, to accept a similar position at General Hospital, Fresno, Calif.

Edna D. Price, R.N. — recently named administrator, Winthrop (Mass.) Community Hospital, was formerly superintendent, Norwood (Mass.) Hospital.

VA Nursing Appointments

Anna M. Aslakson — has been assigned as assistant chief, nursing service, VA Hospital, American Lake, Wash. She was formerly the acting assistant chief, nursing service, at that station.

Dorothy A. Blush—has been transferred to the Fayetteville, Ark. hospital as assistant chief, nursing education. She was formerly a clinical instructor at the VA Hospital, Topeka, Kan.

Lillie Brown — is assistant chief, nursing service, VA Hospital, Hines, Ill. She was formerly a supervisor at the same hospital.

Margaret Cody—is chief, nursing unit, VA Regional Office, Kansas City, Mo. She was formerly the acting chief, nursing unit, at that station.

Katherine C. Cox—has been transferred to the new Birmingham, Ala., hospital as chief, nursing service. She held a similar position at the Beckley, W. Va., hospital.

Isabella Coutts—is attending New York University. She was formerly

(Continued on next page)

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area chief nursing service, VA Area Medical Office, Atlanta, Ga.

Marion Dacey—is the chief, nursing service, VA Hospital, Providence, R.I. She held a similar position at the hospital in Boise, Idaho.

Catherine Dughi—is chief, nursing service, VA Hospital, Martinsburg, W. Va. She was formerly assistant chief, nursing service, at the hospital.

Grace Fortenberry — is assistant chief, nursing service, VA Center, Shreveport, La. She was formerly supervisor at the hospital.

Esther Edgar—is assistant chief, Nursing Service, VA Hospital, Bronx, N. Y. Prior to this transfer she held a similar position at the hospital at Framingham, Mass.

Alice Erhart — is assistant chief, nursing education, at the new VA Hospital, Kansas City, Mo. She was formerly an instructor at the hospital at Brooklyn.

Grace Farley—is the assistant chief, nursing service, at the new VA hospital, Syracuse, N. Y. She held a similar position at the hospital in Jackson, Miss.

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Gladyce E. Garst—has been assigned as chief, nursing service, at the Beckley, W. Va., hospital. She was formerly the assistant chief, nursing service at that station.

Marie R. Glander—has been assigned as the assistant chief, nursing service, at the new Birmingham, Ala., hospital, following a period of orientation at the VA hospital, Hines, Ill. She was formerly surgical supervisor at Gouverneur Hospital, N. Y.

Nellie Godwin — is an assistant chief, nursing service, VA Hospital, Houston, Tex. She was formerly a supervisor in that hospital.

Elva Holland — is assistant chief, nursing education, VA Hospital, North Little Rock, Ark. She was formerly acting assistant chief, nursing education, at that station.

Katherine Kerrigan — is assistant chief, nursing service, VA Hospital, Martinsburg, W. Va. She was formerly a supervisor at the hospital.

Ann Markiewicz—is assistant chief, nursing unit, VA Office, Lowell, Mass. She was formerly assigned to the regional office, Boston.

Edna V. Mitchell—has been assigned as chief, nursing service, Dearborn, Mich., hospital. She was formerly the acting chief, nursing service, at that station.

Harriet McIsaac—is assistant chief, nursing service, VA Hospital, Canandaigua, N. Y. She was formerly assigned to the hospital at Amarillo, Tex.

Irma M. Olson—has been transferred to the new hospital in Birmingham, Ala., as the assistant chief, nursing education. She held a similar position at the Beckley, W. Va., hospital.

Katherine Prentiss — is assistant chief, nursing service, VA Hospital, Boston. She was formerly a supervisor at that hospital.

Ruth Rochell — is assistant chief, nursing education, VA Center, Shreveport, La. Prior to transfer she held a similar position at the hospital at McKinney, Tex.

Jean Sperry—is chief, nursing service, VA Hospital, Boise, Id. Prior to transfer she was the assistant chief, nursing service, at the hospital at Long Beach, Calif.

Sadie L. Wheless—has been transferred to the new Durham, N. C., hospital as chief, nursing service. Prior to transfer she held a similar position at the Montgomery, Ala., hospital.

(Continued on page 66)

7:45 A.M. Room A Suprapubic Pr
8:00 A.M. Amphitheatre Cholecystecto
8:00 A.M. Room B Thyroidectomy
8:15 A.M. Room C Radical Maste
8:45 A.M. Room A2 Submucous Res
9:30 A.M. Amphitheatre Resection of

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THROMBIN TOPICAL acts directly on the blood fibrinogen to form a firm, adherent, *natural* clot, producing hemostasis in a matter of seconds. Whether you spray, flood or dust it onto affected surfaces, THROMBIN TOPICAL helps control capillary bleeding in abdominal surgery, brain and bone surgery, skin grafting, nose and throat operations, prostatic surgery, dental extraction, bleeding incident to drainage, excision or debridement, and many other operative procedures.

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PERSONALLY SPEAKING continued

Loretta E. Zuver—has been assigned as assistant chief, nursing service, Dearborn, Mich., hospital. She was formerly a medical nursing supervisor at that installation.

R. L. Purser—is now assistant administrator, Washington County General Hospital, Greenville, Miss. He was formerly a consultant with the Mississippi Commission on Hospital Care.

James R. Pepper — has been appointed assistant director, Southside Hospital, Bay Shore, N. Y., succeeding **William A. Kozma**, whose appointment as administrator, Long Beach (N. Y.) Memorial Hospital, was announced in the March issue.

J. Milton Roberts—formerly administrator, Washington-St. Tammany Charity Hospital, Bogalusa, La., is now administrator, Bogalusa Medical Center. He replaces **Ross Garrett**, who resigned to become a hospital consultant in Texas. Mr. Roberts' successor at the Washington-St. Tammany Charity Hospital is **Hubert Richard**.

Louise Rothenberger — is superintendent, occupational therapy department, new VA Hospital, West Haven, Conn.

John Stagl—has been named assistant director, Passavant Memorial Hospital, Chicago. Previously he was business manager of the hospital.

Millard Wear—who has been acting administrator, Kennestone Hospital, Marietta, Ga., since December 1, has been named administrator.

Robert W. Wencil—new administrator, Chicago Physicians' and Surgeons' Hospital, previously was administrator, Naeve Hospital, Albert Lea, Minn.

George Wyman, M.D.—will succeed **A. M. Lyon, M.D.**, as superintendent, Central State Hospital, Lakeland, Ky. Dr. Lyon's resignation was announced in the January issue. Dr. Wyman has been assistant superintendent and clinical director, Madison (Ind.) State Hospital, since September, 1952.

Betty Jean Yapp—former administrative dietitian, Mary Lanning Memorial Hospital, Hastings, Neb., now holds a similar position at Lincoln (Neb.) General Hospital.

Deaths

George Henry Davis, M.D.—75, who with his wife had owned and operated the Kirkland (Wash.) Hospital since 1928, died March 5.

John Dorning, M.D.—93, formerly medical director, St. Francis Hospital, Bronx, N. Y., for several years until his retirement in 1942, died April 13.

S. R. Forkosh, M.D.—medical director, Manor Hospital, Chicago, died in March.

Rudolph W. Holmes, M.D.—80, former chief, department of obstetrics, Passavant Memorial Hospital, Chicago, and associate professor, department of obstetrics and gynecology, Northwestern University Medical School, died April 25 in Charlottesville, Va. He retired 10 years ago.

Dean S. Luce, M.D. — 77, named "family doctor of the year" by the AMA in 1950, died April 9 in Canton, Mass.

John J. MacDonald, M.D.—80, assistant medical director, Hudson County General Hospital, Secaucus, N. J., died April 6.

Sister Helen Morrissey—92, founder, St. Mary's Hospital, Montreal, Que., Canada, died April 9.

M. L. Perry, M.D.—84, former superintendent, Topeka (Kan.) State

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Hospital, died April 10. He had been superintendent for 30 years before his retirement in 1948.

St. Louis University Announces Residencies

The St. Louis University School of Hospital Administration has announced the following appointments to residencies for the class of 1954:

William Andrews — to **Sister Andrea**, DePaul Hospital, St. Louis.

James deSpelder — to **Kenneth B. Babcock, M.D.**, Grace Hospital, Detroit.

Adalbert Dierks—to **Frank R. Bradley, M.D.**, Barnes Hospital, St. Louis.

Lester E. Johnson — to **Frank S. Groner**, Baptist Memorial Hospital, Memphis, Tenn.

William B. Jones—to **T. G. Blocker, Jr., M.D.**, University of Texas Medical Branch Hospital, Galveston.

Stephen Morris—to **G. M. Banner**, Good Samaritan Hospital, Phoenix, Ariz.

John Shaw—to **C. E. Copeland**, Missouri Baptist Hospital, St. Louis.

Erna Simek and Frank Simek—to **Frank R. Bradley, M.D.**, Barnes Hospital, St. Louis.

Richard Gaeckle, Charles Stumpf, Ben Tobias, and Richard Yarmain will go to the Army, and **Bryan Rogers'** future plans have not been revealed.

Clinic Administrators Form New Group

The Conference of Clinic Administrators was formed recently at Louisville, Ky., for the interchange of ideas on problems common to all types of clinics.

Harry Panhorst, Washington University Clinics, St. Louis, was elected president of the new organization. Other officers are **Carl F. Arntson**, Linville Memorial Clinic, Columbia City, Ind., president-elect; **Robin C. Buerki, Jr.**, Bailey Thoracic Clinic, Philadelphia, vice-president; and **Eva M. Rule**, Olney Sanitarium, Olney, Ill., secretary-treasurer.

Charter memberships are now being accepted.

Chicago Council Elects

Ralph M. Hueston and **Leslie D. Reid** are the new president and president-elect, respectively, of the Chicago Hospital Council.

Mr. Hueston, superintendent, Wesley Memorial Hospital, succeeded **Ray E. Brown**, superintendent, University of Chicago Clinics.

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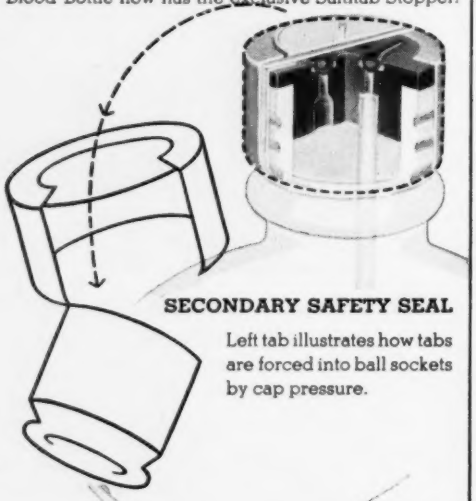

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Left tab illustrates how tabs are forced into ball sockets by cap pressure.

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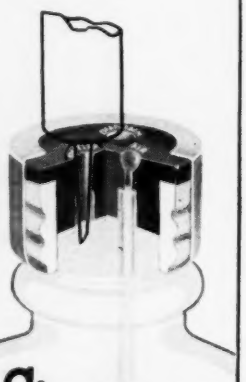

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A REAPPRAISAL of Absorbable Glove Powder

An Article by

D. Marshall Lee, Jr., M.D., W. T. Collins, M.D. and T. L. Largen, M.C., Departments of Surgery and Pathology, College of Medicine, University of Cincinnati, Cincinnati, O.

Reprinted from "Surgery, Gynecology and Obstetrics," December, 1952, Vol. 95, 725-737. *Copyright, 1952, by The Franklin H. Martin Memorial Foundation.*

• Several years ago, in association with Dr. E. P. Lehman, one of the present authors presented a report* (3) dealing with the dangers of talcum powder as a glove lubricant, and describing studies of a powder derived from corn starch as a suitable replacement for talcum. These findings were subsequently confirmed by other investigators, and a recent sample survey indicates that talcum has been replaced by the starch derivative powder in the operating rooms of 60 to 90 percent of the hospitals in the United States.

It has been well established that this starch derivative powder is vastly superior to and less hazardous than talcum powder. However, as is so often the case when a new therapeutic agent is developed, there is a tendency to lose sight of its limitations. When one hazard has been eliminated, whether partially or completely, it is easy to fall into the trap of assuming that the illusory "foolproof preparation" has been achieved and to throw caution to the winds. A widespread impression seems to have developed that starch powder is "perfectly safe." There has been a tendency to discard entirely the scrupulous effort to minimize powder contamination of the operative field, which was encouraged when talcum powder was in general use. A growing appreciation of this dangerous trend, together with a recognition of certain deficiencies in the earlier studies, has prompted experimental reappraisal of the effects of absorbable glove powder.

Evaluation of the effects of glove powder is based on several basic considerations from both the clinical and experimental standpoint.

1. The production by contaminating powder of adhesions on serosal surfaces or of granulomas in the soft tissues is the result of a foreign body reaction.

2. The production of adhesions and granulomas by contaminating talcum powder is the result of both chemical irritation and a foreign body reaction, although the latter clearly predominates. The fact that talc crystals are insoluble, and for practical purposes nonabsorbable, makes the reaction essentially an irreversible and permanent one.

3. Within limits, treated starch powder has been shown to produce a much less violent reaction than does talc. Provided all other factors conducive to inflammatory reaction and adhesion or granuloma formation are excluded, starch powder appears to be completely absorbed and it leaves the serosal surfaces and soft tissues undamaged. But until absorption takes place, the starch granules constitute as much of a foreign body as would any other powder of comparable particulate size. The longer the granules remain unabsorbed, the more advanced the foreign body reaction will be, and the less chance there is that it will be reversible. When a complicating factor such as infection is added to the foreign body reaction of tissues, the process is much more violent and the extent of permanent scar tissue formation is proportionately increased. These facts have apparently been overlooked, and the oversight has led to an exaggerated confidence in the safety of treated starch as a glove powder.

See January, 1950 issue, page 42, also the O.R. Yearbook, Volume I, page 9.

PREVIOUS EXPERIMENTS

In our previous animal experiments, which demonstrated the superiority of treated starch over talcum powder, the interval between implantation of the test material and reexamination of the contaminated peritoneum was three weeks. It was shown that under ideal conditions, starch powder was absorbed without ill effect, as compared with dense adhesion and granuloma formation when talc was used, but no studies were included to evaluate the reaction to starch during the three-week interval. It is apparent that any absorbable foreign material, including the familiar surgical catgut, produces a tissue reaction before it is absorbed and that the severity and final effect of this reaction depends on a variety of factors.

It is not within the scope of the present discussion to review in detail the pathological physiology of the foreign body reaction. In spite of the extensive literature, really fundamental study of this subject is still in its infancy and conclusive information is very meager. E. P. Lehman,

TABLE I.—SERIES I (28 DOGS)

Test material	Average number of adhesions			
	1-2 days	3-7 days	8-15 days	16-21 days
Starch+MgO (2%)	14 [2]	12 [2]	10 [3]	4 [4]
Starch+$MgCO_3$ (3%)	9 [2]	11 [3]	5 [3]	4 [6]
Control (No powder)	—	—	—	2 [3]

The small figure in the upper right corner indicates the number of dogs from which the average adhesion count was obtained.

co-author of our previous publications on treated starch, has recently summarized (4) the information that is available regarding the reaction of living tissues to foreign materials. His thought-provoking appraisal of this complex problem should serve the double purpose of stimulating further study and of reaffirming the dangers inherent in the use of even the best absorbable materials in surgery. One paragraph of Lehman's discussion is particularly pertinent to the considerations to be presented here:

"It is clear that any discussion of the tolerance of tissue for foreign material must be based on the assumption that infection is absent. Gross infection is easy to recognize, but minor degrees of contamination by bacteria, promptly controlled without resulting gross infection, are not easy to measure in experimental studies. And yet, the minimal inflammatory reaction accompanying the destruction of undetermined bacterial contamination may modify the extent and the quality of the tissue reaction to the foreign material itself. It must be recognized in all studies of the foreign body reaction that this indeterminate factor may be present. With this reservation always in mind, let us try to define what is meant by tissue tolerance."

MULTIPLE VARIABLES

He goes on to list and to comment upon the multiple variables which influence the reaction of tissues to foreign material. These include: (1) the size and nature of the wound; (2) the amount or particulate size of the foreign material; (3) the wetability of the material; (4) the physical quality and behavior of the material, including electric potential, crystalline structure, piezoelectric qualities, and radioactivity; (5) chemical characteristics of both the material and the host, including soluble and insoluble impurities, formation of secondary substances by the interaction of the material with the serum or interstitial fluid of the host, cytotoxic effects, hydrogen ion concentration, tissue enzymes, and protein reactions; (6) variations in the host, such as specific responses of a given type of tissue, or differences in the host as a complete organism (Thus the response may vary in the same individual under different conditions of health and disease, or individual and species differences may be pronounced); (7) antigen-antibody reactions.

Even this brief recapitulation of the factors to be considered in estimating the effect of a glove powder in tissue should be sufficient to indicate the caution with which any such powder should be used. Little fundamental information is available about the reaction of tissues to starch, either treated or untreated.

In this connection, and at the risk of free quotation to the point of plagiarism, another of Lehman's comments is important. He says: "The traditional empirical method of testing materials for surgical use in the tissues of animals and man is not profitable from the fundamental point of view. It remains necessary, however, in this era of heretofore unknown chemical compounds. Until prediction is possible, every new compound with possible surgical usefulness must be tested empirically, (though) it is a wasteful and uncertain method."

In common with our own and other previously reported studies, the work here presented is of an empirical nature and subject to the limitations inherent to that approach. Moreover, it does not provide answers to a number of questions which might be sought on an empirical basis. It is believed, however, that convincing evidence is afforded in support of the conclusions which follow, the application of which to surgical practice seems important.

OBJECTIVES OF THE PRESENT STUDY

The starch powder now in general use consists (1) of "a biologically absorbable powder prepared from corn starch by etherification with epichlorohydrin. The starch polymer chains are persumably cross-linked by 1, 3, diether glycerin groups to the extent of not more than two percent of the original starch weight. The starch derivative powder is mixed with two percent magnesium oxide, and contains small residual amounts of sodium sulfate and sodium chloride."

Various investigators, including ourselves, have demonstrated the complete absorbability of this preparation in living tissue. The "tanning" process with epichlorohydrin renders the starch granules resistant to autoclaving but cannot be shown to affect either the tissue tolerance or the absorbability of the starch, as long as it is well dispersed in fine particles. It is obvious that "clumps" or masses of this or of any other powder imbedded in tissue will produce more reaction and absorb more slowly. It is desirable, therefore, from the standpoint of both lubricating qualities and tissue tolerance, to keep the powder as finely dispersed as possible. In the original development of the experimental powder (2) 10 or 12 different dispersal agents were tested. For various reasons, only magnesium oxide and magnesium carbonate were found to be acceptable. In the commercial preparation, as noted above, magnesium oxide in two percent concentration is added as a dispersal agent. Although our previous studies indicated that this addition, in the concentration used, was harmless to tissues, some question was raised about it. Seelig believed, on the basis of tests for aldehyde with Schiff's reagent, that paraldehyde had been used in the tanning process. Postlethwait and his associates (7)

TABLE II.—SERIES II (66 DOGS)

Interval from implantation until adhesion count, days	Starch with MgO			Starch with $MgCO_3$			Control—No powder		
	Greatest No. of adhesions	Smallest No. of adhesions	Average No. of adhesions	Greatest No. of adhesions	Smallest No. of adhesions	Average No. of adhesions	Greatest No. of adhesions	Smallest No. of adhesions	Average No. of adhesions
2	22	5	10.5 [9]	19	4	13.8 [6]	0	0	0 [2]
18	34	0	9.9 [14]	22	0	10.7 [13]	1	0	.33 [3]
25	10	2	5.1 [7]	13	0	6.2 [8]	5	1	2.2 [4]

The small figure in the upper right corner indicates the number of dogs from which the average adhesion count was obtained.

demonstrated that the faintly positive reaction with Schiff's reagent was due to the presence of magnesium hydroxide, derived in solution from the magnesium oxide dispersal agent. Further chemical studies by Davis and George showed that after prolonged storage, appreciable amounts of the magnesium oxide are converted to magnesium carbonate. It seems possible, therefore, that a more stable glove powder might result from the initial use of magnesium carbonate as the dispersal agent. This was one of the two agents found to be acceptable in the original studies, although to be effective, a three percent concentration must be used, as compared with two percent of magnesium oxide.

COMPARISON STUDIES

One purpose, then, of the present study has been to compare, under standard conditions, the relative tissue tolerance toward two identical starch powders in which magnesium oxide and magnesium carbonate, respectively, have been added as dispersal agents.

Another question to which an answer has been sought is the degree and extent of peritoneal reaction which takes place during the interval of six to 25 days prior to complete absorption of the powder. This question has already been studied to a limited extent in both dogs and rabbits by Postlethwait and his associates. They found that the rate of absorption of the powder varied considerably, from as little as 24 hours to as much as 12 days. Their study illustrates the very marked species and individual variation in tissue reaction to foreign bodies and in adhesion formation. The great difference among individuals, in their tendency to form adhesions and in their ability to absorb them, is familiar to all clinical surgeons, and it is one of the variables mentioned by Lehman as contributing so much to the inaccuracy of empirical experimental studies. It was felt that if tests were made on a larger series of animals, statistically significant comparisons might be achieved.

It was believed that the study might produce evidence to emphasize the fact that in spite of the demonstrated superiority of treated starch over talcum powder as a glove lubricant, due precautions should nevertheless be taken to minimize contamination of any wound with starch powder, since no foreign material, even if it is ultimately absorbable, is entirely innocuous.

METHOD

The basic procedure of the present study is essentially the same as that previously employed. Dogs were used in all the experiments because it is believed that the reaction of the canine peritoneum more nearly approximates that in the human patient than is the case with other experimental animals. The dog is large enough to permit a closer experimental parallel with conditions in a standard operation on a human patient. The experimental cycle consisted of laparotomy under careful aseptic conditions with delivery of the small bowel. In test animals, the entire small bowel and mesentery from the ligament of Treitz to the ileocecal valve was dusted as evenly as possible with a measured amount of test powder. No matter how carefully this was done, the distribution was uneven, with clumps of powder, obviously difficult to absorb, in some areas, and with finely dispersed particles in others. This fact is important and will be commented upon later. In control animals, the bowel was handled in an identical way but no powder was applied. In all operations, gloves were first carefully washed in running water.

After intervals ranging from one day to 25 days, the animals were either sacrificed or reoperated upon through a new incision on the opposite side of the abdomen, and the adhesions were counted, using the method of Lehman and Boys (5). As these authors have pointed out, this represents only "an exceedingly rough quantitative estimation of results," but to our knowledge it is the only method available for a quantitative comparison of the effects of various agents. To express these results in numerical terms is inaccurate to a degree, and exposes them to considerable misinterpretation. Bearing in mind the many variables emphasized by Lehman, the presence of 8 or 10 fine, tenuous adhesions in an otherwise clean and glistening peritoneum may actually indicate much less reaction than four or five large sheet-like adhesions between mesentery and mesentery, bowel and bowel, or mesentery and bowel. Hence, too much emphasis should not be placed on the numerical results. We have, therefore, attempted to compensate for this obvious inaccuracy by illustrating the differences photographically. Nevertheless, the numerical count of adhesions in a large enough series of animals

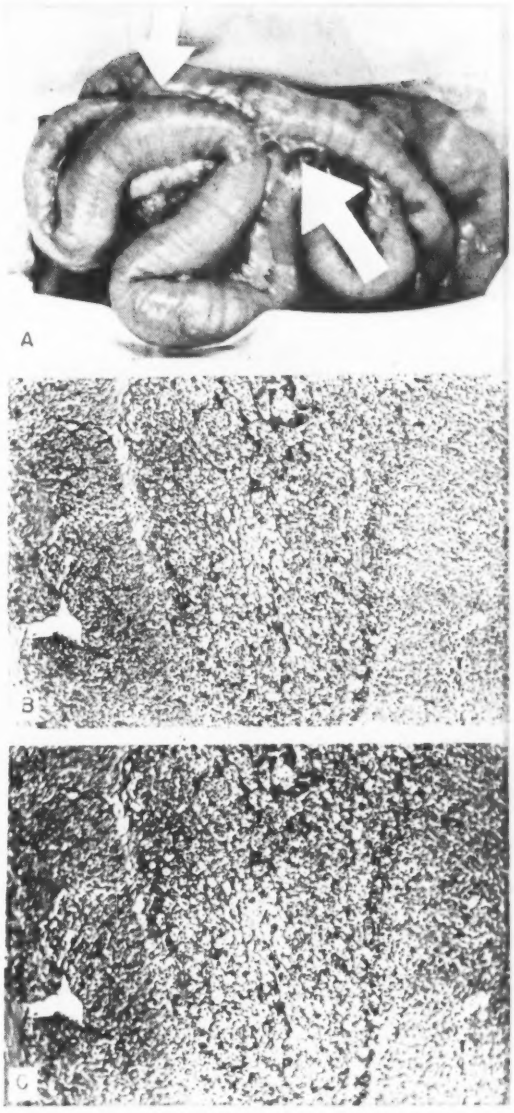


Fig. 1. Dog 877. Starch powder with two percent magnesium oxide —24 hours. a, Gross appearance of the bowel. The serosa is dull and lusterless, as it appeared immediately after dusting. Adhesion count—14. b, Section through an adhesion as seen under ordinary illumination. ×75. c, The same field as that shown in b, with partial rotation of the polarizing discs. The adhesion is seen to consist of acute inflammatory exudate interspersed in which are numerous starch granules.

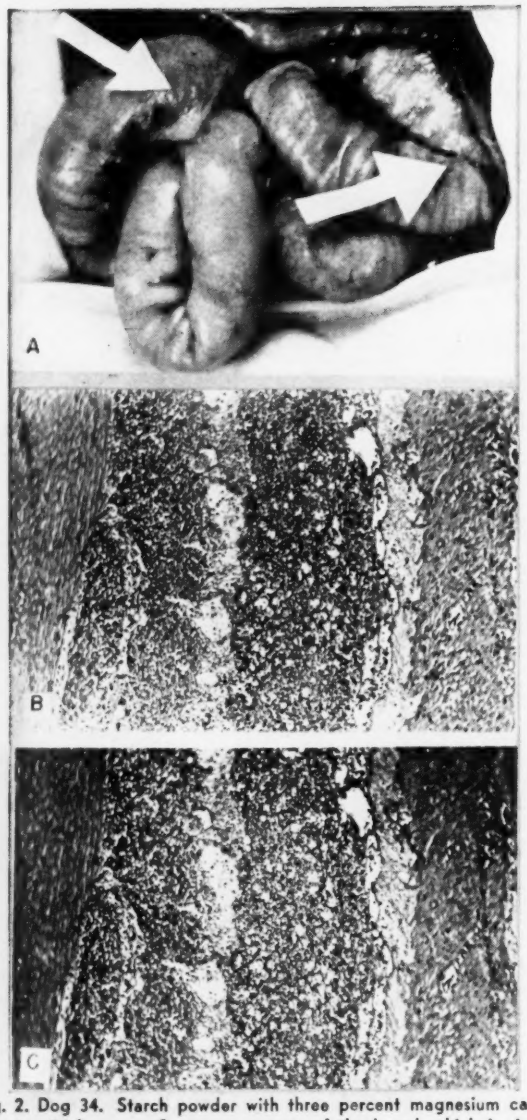


Fig. 2. Dog 34. Starch powder with three percent magnesium carbonate—24 hours. a. Gross appearance of the bowel, which is similar to that of the animal in Fig. 1. Adhesion count—21. b. Section through an adhesion, with ordinary illumination, ×75. c. The same field as that shown in b, with partial polarization of the light. ×75. The findings do not differ significantly from those shown in Fig. 1.

has some comparative statistical significance.

As a further check on the gross observations, representative adhesions were removed en bloc when present, and paraffin sections were prepared for microscopic examination under normal and polarized light. In the same animals, the lymph nodes at the root of the mesentery were also removed for similar study. It was hoped that the character and degree of inflammatory reaction might throw some light on the presence or absence of subclinical infection. Since intact starch granules are readily identified under polarized light (by the characteristic maltese cross), it was also hoped that the progress and mechanics of absorption might be followed. These efforts met with only very limited success.

PROCEDURE

In all of the present experiments on dogs, the test dose of powder was ½ teaspoonful. For reasons indicated in our previous report, a volumetric measure appeared to be preferable to a weighed dose, and in the earlier studies ½ teaspoonful of starch derivative powder was found to weigh approximately 1.0 gram. This is a large dose in the peritoneum of a dog and constitutes a much more severe test of the powder than would ever be likely to occur in clinical practice, even after perforation of a glove. It represents the rough equivalent of all the powder that can be washed from the surfaces of eight pairs of surgical gloves which have been prepared for routine use in the operating room.

In the course of this study, 100 dogs were operated upon. This large number of dogs taxed our kennel facilities severely and it was impossible to keep each animal long enough, before operation, to be sure that he was in good physical condition. Many dogs were operated upon the same day or the day after they were received from the dealer. As a result of this, 16 dogs died of distemper or of its complications, before the assigned day for their second operation and adhesion count. In three other dogs, the test was invalidated by obvious wound infection. In one dog, the proper identification of the test powder was questionable and this animal was, therefore, eliminated from the series. Thus 20 out of 100 animals were invalidated.

The remaining 80 dogs, whose wounds healed without gross evidence of infection and who were re-examined on schedule, still left much to be desired in terms of general physical condition. Virtually all of them were infested with worms, malnutrition was common, and many had been previously used in another series of experiments dealing with the healing of small burns of varying depths on the skin of the back. Thus a wide range of variables was introduced, which may explain why a few adhesions were produced even in the control dogs where no powder was applied to the peritoneal surfaces. It must be remembered, however, in terms of the application of the experimental results to clinical surgery, that ideal conditions are seldom achieved when the human peritoneum is exposed. In appendicitis, perforated ulcer, or intestinal resections of any kind, either bacterial or chemical contamination, or both, are present in varying degree. Where hemoperitoneum, either prior to or as a result of surgery is encountered, another variable is introduced. The relationship of the enzymes associated with malignancy to foreign body reaction is entirely unknown, so that in operations for human abdominal carcinoma, still another variable is present. Therefore, since the study was designed to simulate actual conditions in human clinical surgery, the fact that the dogs were not uniformly in perfect health did not seem necessarily undesirable.

RESULTS

Series I. In the first series, a base line was sought by using a small series (28 dogs) of animals and by conducting the adhesion count at frequent intervals, ranging from one day to 21 days. It was hoped that by this means a rough estimate of tissue tolerance and rate of absorption of the powders could be obtained. It was not expected that this series would be statistically significant, but only that it would aid in determining at what intervals a larger series of animals might most profitably be studied. The results of this series of experiments are summarized in Table I.

No valid conclusion can be drawn from this series. In a few instances, where the interval between implantation and adhesion count coincided with the intervals in the first series, the same animal was included in the second series, since this increased the statistical sampling without vitiating the results in either series.

Series II. In the second series, 66 animals were evaluated. Of these, 17 were examined after two days, 30 after

18 days, and 19 after 25 days. The statistical results are summarized in Table II.

It is seen from this table, that even with a relatively large dose of powder, adhesion formation is not extensive, regardless of which dispersal agent is used. In comparison with talcum powder, as demonstrated in our own and other previous studies, the reaction is not severe, but there is nevertheless enough reaction to merit serious consideration and a conscientious effort to avoid it. The rather wide range in the number of adhesions reflects the introduction of variables such as subclinical infection, health of the animal, uneven application of test powder, and variations in the degree of trauma during operation, as outlined in the preliminary discussion.

It was pointed out previously that in an empirical, and therefore necessarily inaccurate study of this kind, with many uncontrolled variables, numerical comparison alone is likely to convey a distorted impression. In the accompanying illustrations, representative examples of the gross and microscopic results are presented which will help to clarify the interpretation.

Figures 1 and 2 indicate the typical appearance of the dog's bowel 24 hours after implantation of the test powders. The reaction is almost identical, regardless of which dispersal agent has been used with the starch powder. The serosal surface of the bowel is dull and lusterless, as it looks immediately after the powder is applied, but no adhesions have formed where the distribution of powder is even and where it has separated into individual granules. Adhesions did develop wherever clumps of powder had fallen. Here, under the microscope, a fresh fibrinopurulent exudate is seen with abundant polymorphonuclear leucocytes. Under polarized light, the mass of starch granules is readily seen. The gross adhesion count appears to reflect the number of such clumps or aggregates of powder granules rather than a general inflammatory reaction such as is seen in bacterial peritonitis. Hence at this early stage, a foreign body reaction to aggregate masses of powder granules seems to dominate the picture, and the total adhesion count of 14 and 28 is not actually significant.

In Figures 3 and 4, the situation after eight days is shown. Polymorphonuclear cells are less numerous, fibroblastic proliferation is present, and foreign body giant cells have appeared. A developing granuloma is now evident and starch granules are still present in large numbers. Except in the areas where these clumps of powder have fallen, a healthy peritoneal sheen is apparent and the serosa looks normal. Thus, where the powder has been well distributed in individual particles, all reaction seems to have subsided. Whether or not the existing adhesions will absorb would then depend on how large a clump of powder produced each one of them and on the indeterminate factors of subclinical infection and other variables. There is no significant difference in the tissue response to the starch powder, regardless of which dispersal agent is used. The difference between eight and 12 adhesions is, therefore, of no experimental importance so far as the two powders are concerned.

The next two groups of photographs illustrate the findings in two dogs in which adhesions were still present after 18 days. In Figure 5 (dog 99), one adhesion remains, while in Figure 6 (dog 88) there were 34 adhesions. In cold figures, this would suggest a wide difference in the reaction to the two dispersal agents. In both dogs, the bowel is normal except where the residual adhesions are present. This suggests that the adhesions have occurred where clumps of powder fell. It is reasonable to suppose that most of the clumps were small in dog 99 and the resulting granulomas did not develop into irreversible fibrous scars. When the starch was digested and absorbed,

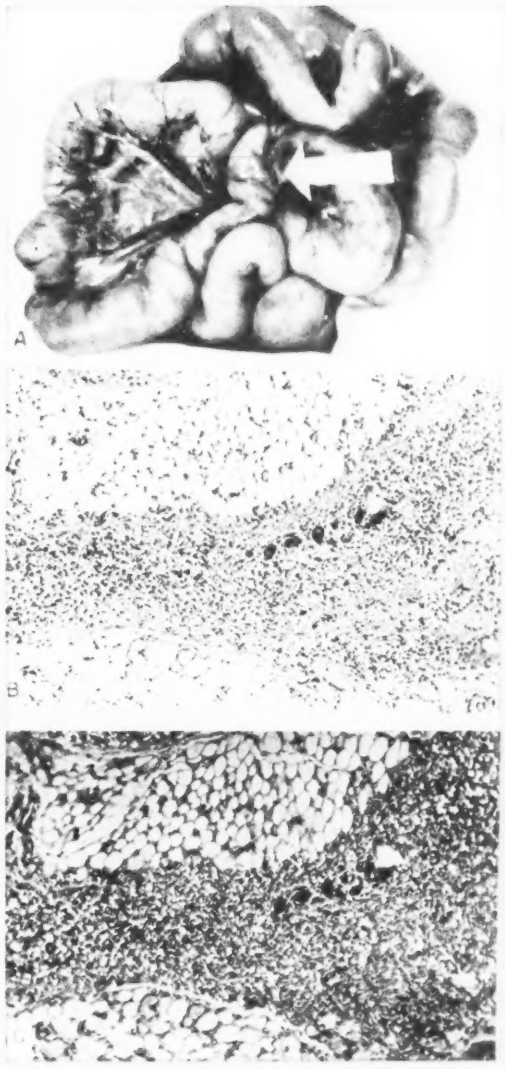


Fig. 3. Dog 43. Starch powder with two percent magnesium oxide —eight days. a, The bowel is clean and healthy looking except where there are adhesions. Adhesion count—12. b, Section through an adhesion, as seen under ordinary illumination. Polymorphonuclear infiltration is much less marked than it was in the 24 hour period but fibroblastic and capillary proliferation are evident. ×75. c, Under partially polarized light numerous starch granules are demonstrated. ×75.

the granulomas disappeared. However, where a large clump fell, even though the starch was absorbed, the process took so long that a fibrous adhesion has remained, which is likely to be permanent. No starch is seen under polarized light and this illustration is, therefore, omitted.

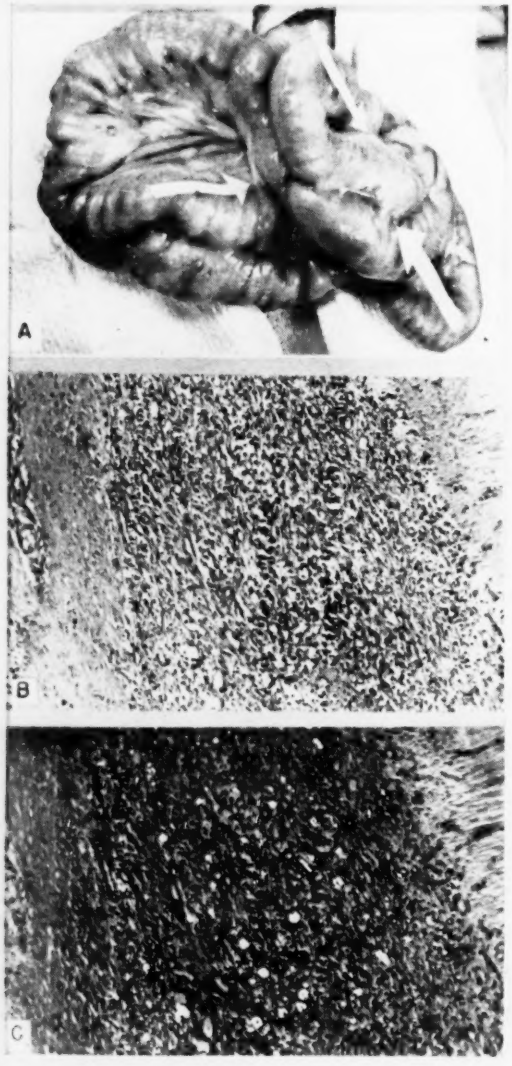
In dog 88, although 34 adhesions are present, their appearance, both grossly and microscopically, suggests that they are very close to complete absorption. A few starch granules remain but there is little or no fibrous proliferation, and when compared with the eight day dogs, it may be surmised that this dog's bowel would have been clean and free of adhesions in a few more days. The animal is actually much better off than the one who has only a single large adhesion of a permanent character. It is presumed that subclinical infection did not play a major part in the persistence of this single adhesion, because if this had been the case, it seems unlikely that the rest of the bowel could have returned so completely to normal. Thus the size of the clump of powder is believed to have

been the determining factor.

Reference to Table II will show that dog 88, with his 34 adhesions, represented the animal with the greatest number of adhesions encountered after 18 days. The average number of adhesions in 27 dogs was 9.9, and most of the animals had no adhesions, as shown in Figure 7, a and b. Their bowel surfaces were usually as clean as were those in the control animals (Fig. 7c). It may be concluded then that unless large powder clumps or masses are present, the adhesions initially formed are absorbed when the starch powder is absorbed, provided ideal conditions of atraumatic and aseptic handling exist.

If infection supervenes, the reaction will certainly be much more violent, and even though the starch, like surgical catgut, is ultimately absorbed, permanent scarring and unabsorbable adhesions may be expected. This situation is exemplified in Fig. 8. In this animal, a gross wound infection indicated that asepsis had not been achieved at

Fig. 4. Dog 55. Starch powder with three percent magnesium carbonate—eight days. a, Gross appearance of the bowel. The serosal surfaces appear normal except where clumps of powder have fallen. Adhesion count—eight. b, Under ordinary illumination the inflammatory process is similar to that seen in Fig. 3, except for the absence of foreign body giant cells. ×75. c, Under partially polarized light starch granules are abundantly present. The gross and microscopic findings are again essentially the same in both eight day dogs.



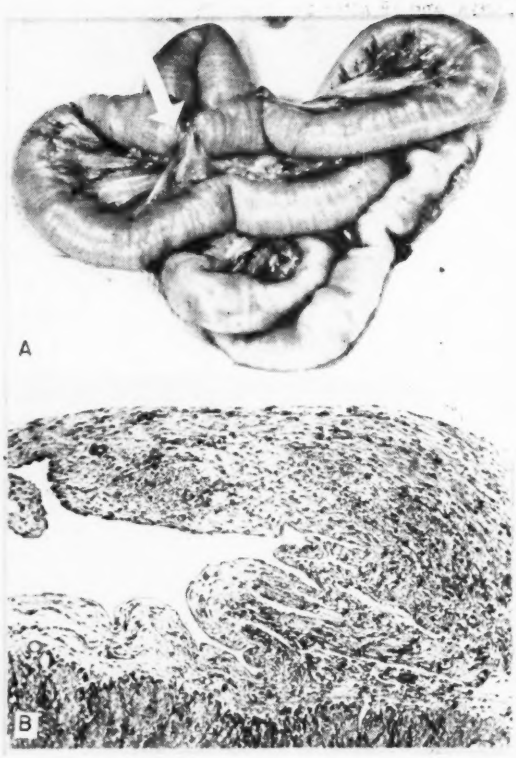


Fig. 5. Dog 99. Starch powder with two percent magnesium oxide —18 days. a, Gross appearance of the bowel. The serosal surfaces appear normal except for a single adhesion. b, Section through the adhesion. A firm fibrous scar is present. c, Under polarized light no starch was demonstrated and is, therefore, not illustrated. ×75.

the initial operation. Twelve days following implantation the entire bowel was fused in a mass of uncountable adhesions, and microscopic section showed not only the starch granules but also a persistently severe inflammatory reaction. This, of course, represents the result of gross bacterial contamination. Somewhere between this extreme and the complete absence of persistent reaction, shown in Fig. 7, will lie the effect of starch powder on a peritoneum in which subclinical infection is present. This is a phase of the problem which defies accurate analytical study.

When an interval of 25 days elasped between implantation and re-examination, the average adhesion count dropped appreciably, suggesting that some of the adhesions produced by powder aggregates were not irreversible and were still capable of absorption. This outcome would seem to depend on both the size of the clump and on the uncontrolled variables. Under average conditions, as long as it is well dispersed, the powder is well tolerated and quickly and harmlessly absorbed. At both 18 and 25 days, most of the animals showed no adhesions, and in those in which adhesions persisted, the surfaces were clean except where large clumps had fallen. That the powder alone could not be held entirely responsible is illustrated by the fact that in the control animals a few adhesions occurred.

Study of sections made from the mesenteric nodes of the test animals showed a complete absence of any starch granules. This fact tends to confirm the observation noted in our previous report that powder particles on the peritoneum are either absorbed or encapsulated where they fall and are not taken up by the lymphatics.

DISCUSSION

Talcum powder was not used in the present study because its use would have represented a repetition of our

own previous experiments and those of many other investigators. It has been established that talcum powder, applied under the conditions of these experiments, consistently produced a violent reaction with uncountable dense adhesions. The present work is not designed to demonstrate the superior safety of starch powder as compared with talcum powder. The dangers attendant upon the use of talcum powder as a glove powder have been abundantly demonstrated by many competent studies and are beyond question. Starch derivative powder has been shown, on equally good evidence, to be much better tolerated and to be as nearly innocuous as it is possible for any sterilizable powder to be. No matter how benign a powder may be, and no matter how quickly it is absorbed, it is, for the duration of its presence in tissue, a foreign body.

The present study has sought to emphasize this important point. The evidence presented indicates that starch powder is well tolerated provided it is properly dispersed into individual granules. The need for a dispersal agent in any starch glove powder is apparent from the results here presented.

Although a review of the extensive literature on the subject would not be worth while here, it is important to remember that the "ideal" glove powder must meet a complex array of minimum requirements. Its physical qualities as a lubricant, its effect on the surgeon's hands, its effect on rubber gloves, and the tissue reaction when it contaminates a wound are all essential considerations. An absorbable, digestible, chemically inert powder such as starch was long recognized as approaching this ideal. The difficulty lay in achieving a sterilizable form of such a powder. The powder derived from polishing raw rice, for example, is finely divided and chemically benign and has been used for centuries in the Orient for cosmetic purposes. But it cannot be sterilized without loss of all its desirable properties as a glove lubricant. The same difficulty applied to other vegetable powders until a method could be found to harden or tan their individual whole granules in order to make them resistant to autoclaving. An early approach was to fix the granules with formalin, but this procedure immediately introduced a strong chemical which living tissue could not tolerate. The "tanning" process mentioned earlier accomplishes the desired result effectively in corn starch, but to assure further the adequate dispersal of the particles, a dispersal agent is added. There appears to be no significant difference, so far as tissue tolerance is concerned, between two percent magnesium oxide and three percent magnesium carbonate as dispersal agents.

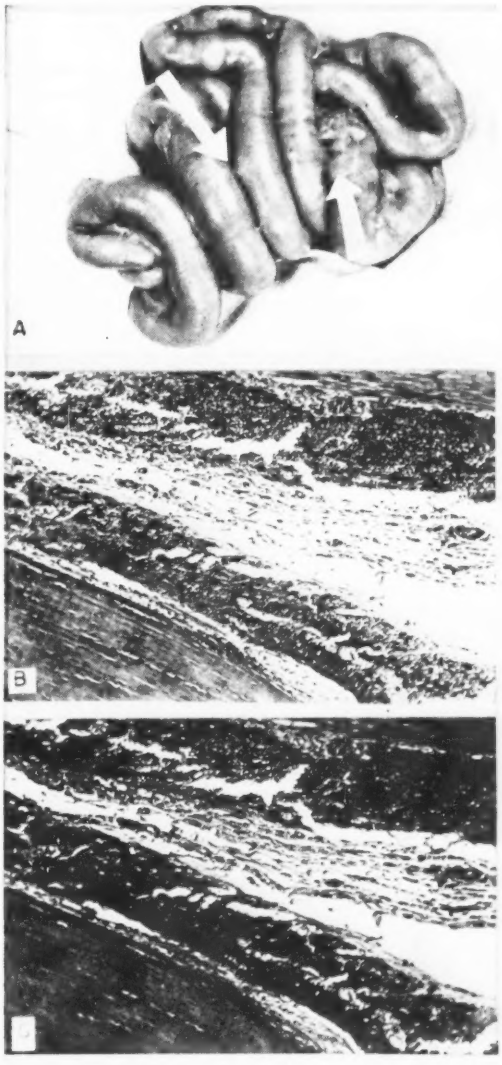
The present study indicates that this dispersal into individual granules is essential to rapid absorption and to minimum reaction in tissue. The starch powder used in these experiments is so finely dispersed after autoclaving, that a number of surgeons have complained that it clouds the air too much when they put their gloves on. In terms of tissue tolerance, this dispersal is highly desirable but it emphasizes one of the precautions which should be taken in using any powder lubricant for gloves.

Although the conditions of these experiments and the quantities of powder used represent a much more rigorous test than ordinarily would be encountered in clinical practice, the results are representative of what may occur when the powder is permitted to contaminate surgical wounds. Clumps of powder can gain access either from heavily powdered glove surfaces or when a glove is accidentally torn or punctured at the finger tips. It is obvious that in clinical practice the bowel would not be dusted heavily with powder as it was in these studies. The fact that the reaction is relatively slight, even under these conditions, is an indication of the desirable qualities of treated starch as a glove powder. More important, however, is the clear implication that this or any other powder is not foolproof. If it is carelessly used, especially in the presence of infection or any of the other variables which are consistently present in clinical surgery, it can produce adhesions which may not be absorbed.

The same precautions which were employed when talcum powder was in general use are still important when starch powder is used. The fact that starch powder is biologically "nonirritating" and absorbable, when finely dispersed, does not mean that the basic surgical principles of avoiding contamination of wounds with foreign material may be abandoned. Air contamination should be kept at a minimum and gloves should be thoroughly washed as free of powder as possible before the operation is begun. If a glove is torn or punctured, it should immediately be replaced and the fresh glove should be washed before the wearer returns to the surgical field.

This is not to say that starch powder is any less safe,

Fig. 6. Dog. 88. Starch powder with three percent magnesium carbonate—18 days. a, The bowel appears healthy except for multiple small friable adhesions. Adhesion count—34. b, Under ordinary illumination a section through one of these adhesions demonstrates its tenuous character. Only a few starch granules are shown (c) to remain when the light is partially polarized. It is believed that such adhesions would progress to complete absorption in a few more days. ×75.



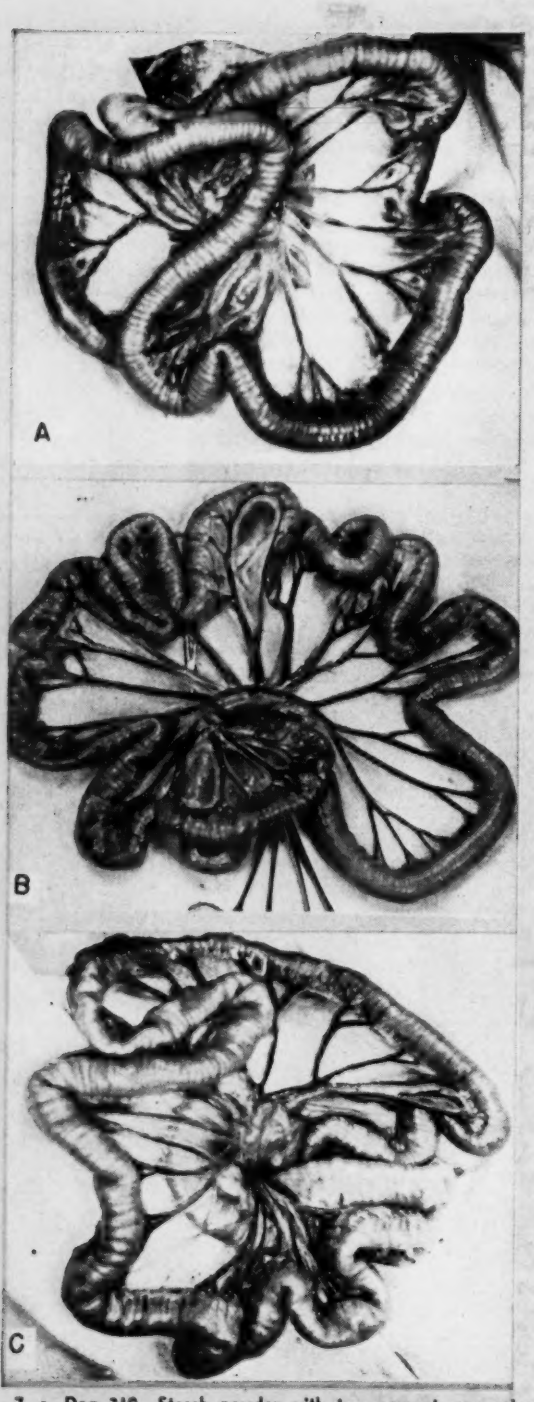


Fig. 7. a, Dog 319. Starch powder with two percent magnesium oxide—18 days. No adhesions. b, Dog 86. Starch powder with three percent magnesium carbonate—18 days. No adhesions. c, Dog 326. Control. No powder used. No adhesions. In general, if the powder was evenly distributed and no clumps or large aggregates were allowed to fall in any given area, absorption was complete in 18 days and no adhesions were formed.

in comparison with talcum or lycopodium powder, than the original studies indicated. We believe that treated starch comes as close to being an ideal glove powder as is theoretically possible. The point is that as long as powder is used as a glove lubricant (and its advantages over the old "wet technic" are obvious), due precaution should be taken to avoid contamination of the wound with the lubricating powder. The preventable hazards inherent in mineral or chemically irritating powders have been eliminated, but the principles of foreign body reaction remain and must be given due consideration.

CONCLUSIONS

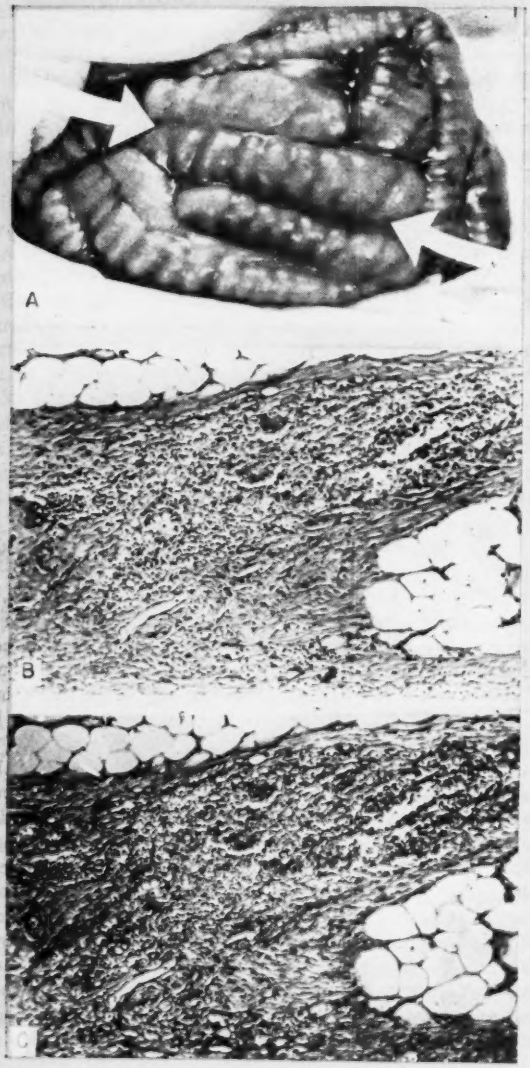
1. Although treated starch powder is biologically absorbable in tissue, it produces a foreign body reaction as long as it is present.

2. The intensity, duration, and reversibility of the foreign body reaction produced by starch granules is influenced by many variables, of which some can be controlled and some cannot.

3. The complete dispersal of the powder into individual granules is essential and is one of the controllable variables. When adhesions are produced by starch powder, they appear to be the result of "clumps" or aggregate deposits which cannot be absorbed as rapidly as can the individual granules. The longer absorption is delayed, the greater is the likelihood that the foreign body reaction will be irreversible and that the adhesions will be permanent. In the absence of infection and under ideal condi-

(Continued on page 78)

Fig. 8. Dog 77. Starch with three percent magnesium carbonate—12 days. A gross wound infection occurred and obvious bacterial peritonitis was present. The entire bowel is fused by adhesions in which a violent inflammatory reaction is seen microscopically. These findings, in the presence of infection, after 12 days, may be compared with those after eight and 18 days in which no demonstrable infection occurred. ×75.



The O.R. Problem Clinic

by EDITH DEE HALL R.N.

● A page set aside for the discussion of administrative problems in the O.R.

O. R. Institute Held in New York Area

● An Institute for Operating Room Supervisors of the New York Metropolitan area was given April 14 and 15 in New York. The two-day session was sponsored by the United Hospital Fund, the Greater New York Hospital Association, the New York City League of Nursing Education, and the New York State Nurses Association, Districts 13 and 14.

Objectives of the institute were two-fold. The first was to present to personnel having supervisory responsibilities in the operating room, some principles of management applicable to their jobs. The second was to provide, by means of a panel and small group workshops, an exchange of ideas and discussion of problems which arise in connection with service in the operating room.

I took brief notes during some of the papers. Although the material is not complete, I hope some of the following will prove beneficial.

C. Kenneth Beach, Ph.D., Coordinator, Training Services, Arabian American Oil Company, spoke on "How to Teach a Job." He gave these steps in Job Instructor Training:

1. Preparation
   a. Trainee: Determine background, education, and experience. Show where the job fits in relation to organization. Put trainee at ease by calling by name. Give trainee sense of belonging.
   b. Supervisor: Determine objectives and establish a course of action. Break down the long job. Make a lesson plan.
2. Presentation
   a. Demonstration: Have a proper place where there will be no interruptions. Have proper equipment at hand. Be realistic. Be sure trainees can see. Explain why. Be enthusiastic. Use simple efficient methods. Build confidence. Repeat demonstration if necessary. Be patient and stress main points. Demonstrate in sequence. Be able to do it yourself and follow through and complete demonstration.
   b. Telling: Be specific and give details. Keep it simple. Be interested, show enthusiasm. Explain new terms. Talk slowly and clearly. Give trainee chance to ask questions and ask questions of the trainee. Teach trainee why. Use visual aids, charts, books, diagrams, etc.
3. Application
   As the supervisor does the job have the trainee tell how and why. Also have the trainee give the demonstration and have her explain how or why.
4. Follow Up
   Check to see that the trainee's practice is correct and give her encouragement. Tell the trainee where to take questions when help is needed. Check the work frequently. Remember to compliment for a job well done. Give additional responsibilities.

"Fundamentals for Staff Morale" was the subject discussed by Wilbur M. McFeely, Director of Industrial Relations, Riegel Paper Corp. Mr. McFeely said that morale is the sum total of satisfaction of individuals in any set-up or organization. Workers need to achieve satisfaction out of their job. This comes through income, recognition, sense of belonging, security, right to be heard, opportunity to grow and develop, and sense of unity.

Good staff morale is a reasonable state of balance. Relationship with the supervisor is important. She may destroy morale indefinitely by injustice or immature nature of using authority. Exceptions must be made, but she should not create martyrs or victims, Mr. McFeely pointed out.

In exercising authority, Mr. McFeely said the supervisor should be conscious of equity, she should guard the self respect of the staff, she should provide for growth and development, she should keep within the limits of her own competence, she should be reasonable. She should anticipate developments and relinquish authority.

"Organization of the Institute for Group Work" was discussed by Kenneth S. Herrold, Ed.D., Executive Officer, Center for Improving Group Procedures, Teachers College, Columbia University. Later Dr. Herrold and his staff illustrated the role of the operating room supervisor on the hospital administrative team. This group demonstrated (1) action under leadership, (2) making a problem census and selection, (3) different steps and technics which precede a conclusion, by using timely topics of general interest.

The institute closed following a Problem Clinic with panel and audience participation. The panel was composed of two surgeons, an anesthesiologist, an administrator, a director of nurses, two operating room supervisors, a central service supervisor, and an admitting clerk. The audience was responsible and interested. Although not a new idea, the use of a surgical committee predominated throughout the institute. It was decided that such a committee is the most helpful means of solving problems relating to personnel and interdepartmental relationships.

The Planning Committee for the institute met several days afterward to evaluate the sessions. Reports were encouraging and the committee concluded that there is a definite need for more programs of this type.

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GLOVE POWDER

(Continued from page 76)

tions, a large dose of starch powder appears to be relatively harmless to the peritoneum provided it is properly dispersed into individual particles which can be absorbed quickly.

4. There appears to be no difference in the tolerance of the peritoneum to treated starch powder, regardless of whether two percent magnesium oxide or three percent magnesium carbonate is used as a dispersal agent.

5. Sterilizable corn starch approaches the theoretical ideal as a powder lubricant for gloves. Nevertheless, any powder, no matter how benign it may be or how quickly it is absorbed produces some degree of foreign body reaction when it contaminates an open wound.

6. Every possible precaution should be taken to prevent powder contamination of open wounds or serosal surfaces, and no powder is so "safe" that it can be carelessly used.

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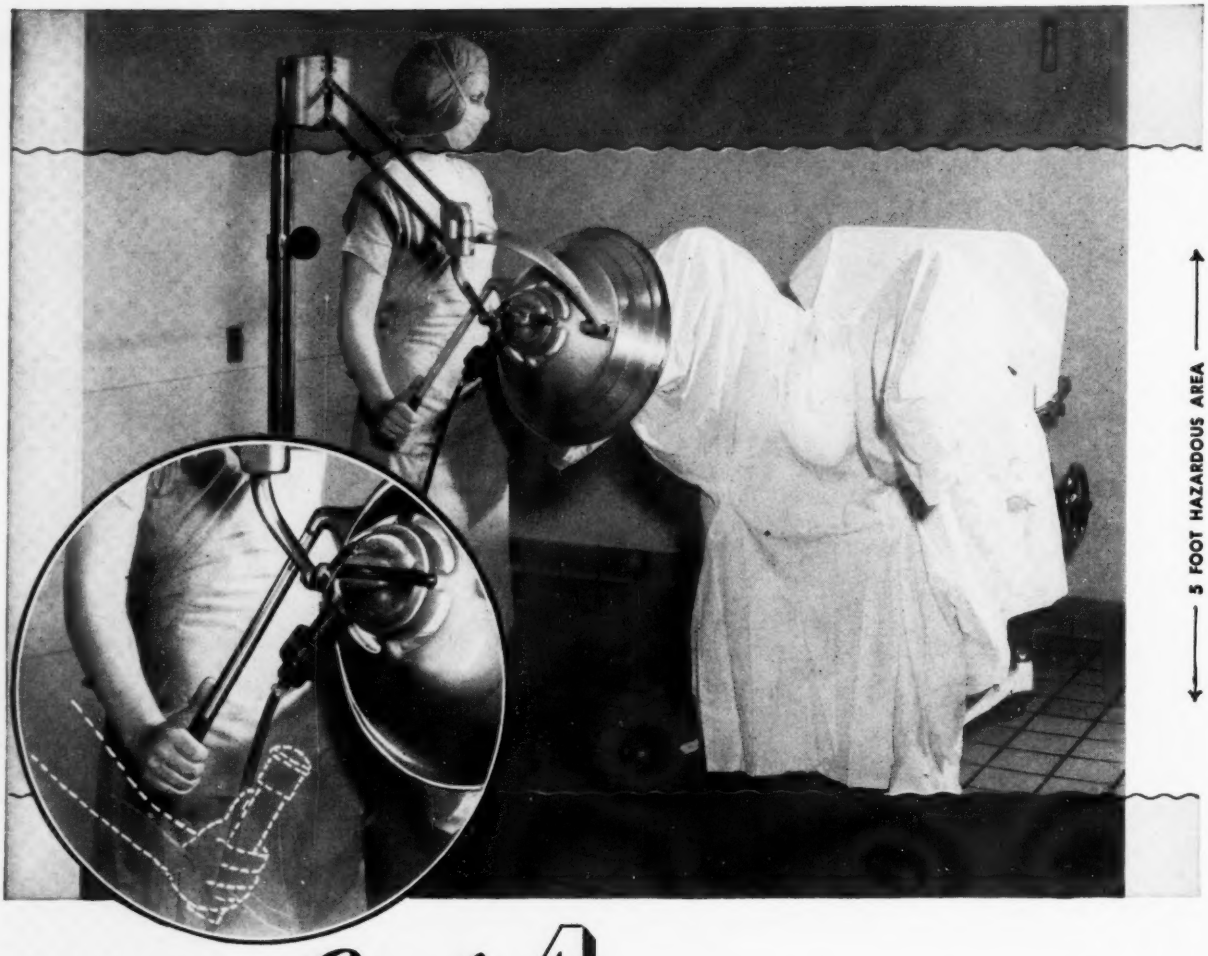

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Work Simplification Applied to the Hospital

By Karl Linderoth
Methods Engineering Council
Pittsburgh, Pennsylvania

The first of two papers presented at Central Supply Section of the Tri-State Hospital Assembly. Next month, "Simplifying the Tasks in Central Supply" by Edna A. Prickett, R.N., University of Pittsburgh.

● Our subject is Work Simplification. We have divided it into two parts. I shall give you some of the background to Work Simplification; the philosophy and principles upon which it rests. Later, Miss Prickett will tell you just how Work Simplification applies to your particular field and what it can do for you in your work.

Methods, and the application of methods, are some of the most common occurrences in our daily life. But we generally give it little conscious thought. And why? Probably because the many methods we use in our daily, personal routine have become so obvious and natural that we do them automatically.

Such simple things as putting the sock on the foot before the shoe; putting the tablecloth on the table before you put the plates on; the logical sequence in preparing food; the planning of the shopping day; and hundreds of other examples demonstrate how we do things all the time according to a certain pattern, following some kind of system. If we didn't plan these things, plan methods for doing them, we would find it difficult to accomplish even the simplest thing. All this, you will say is nothing but common sense! And that is very true. And so it is with Work Simplification or Methods Engineering, as it is known in industry.

Someone has stated very aptly, that the art of methods engineering is nothing but common sense systematically applied. That does sound very simple, doesn't it? But unfortunately we are not as systematic as we think we are, or as we would like to be, in the application of the best method in our daily routine. The more we get used to a system or procedure the blinder we become, until circumstances make us experience personal discomforts or perhaps economic losses. Not until then do we look into the matter and take steps to correct the faults.

One of the basic principles of Work Simplification is to avoid this situation insofar as possible. In other words, make the change before we are forced to do so. Otherwise, it may be too late, or might have caused serious and unnecessary inconveniences. In order to comply with this principle, however, we must first know all the facts about the activity we wish to study, that is "make a diagnosis of the case." Then we need some kind of tools to measure the individual and collective effects of these facts.

The "diagnosis," or analysis and the tools, are known as Modern Management Technics. These technics are not devised overnight. In spite of the logic in doing things the best way and with the least expense, there was a time, and not too long ago, when very little scientific approach was made to management problems.

Today, we are all benefiting from these technics in one way or another. Without time and motion study, improved methods, and working conditions, wage incentives based on accurately determined time standards, etc., modern industry would never have reached its present efficiency and

(continued on next page)

HOSPITAL METHODS ANALYSIS SHEET
Methods Engineering Council
Pittsburgh

Date: _____ Department: _____

Procedure or task: _____

Classification of worker: _____

DETERMINE AND DESCRIBE	DETAILS OF ANALYSIS
1. PURPOSE OF PROCEDURE OR TASK	Why is the task performed? Can purpose be accomplished better otherwise?
2. COMPLETE LIST OF ALL STEPS IN THE PROCEDURE OR TASK: No. Description Work Station Dept. 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____	Can procedure being analyzed be eliminated? be combined with another? be performed during idle period of another? Is sequence of procedures or tasks best possible? Should procedure or task be done in another department to save cost or handling?
3. QUALITY REQUIREMENTS a. Of previous procedure or task b. Of this procedure or task c. Of next procedure or task	Are the requirements necessary? Why? too costly? suitable to purpose?
4. MATERIALS Supply materials	Consider size, suitability, ease of handling and condition. Can less expensive material be substituted?

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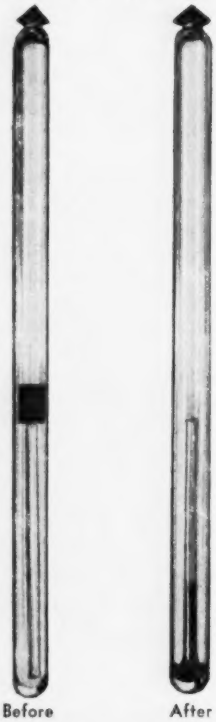

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production. This has led to a spectacular rise in the standard of living. This is particularly true in this country, where we are fortunate to live under a system which permits scientific management to be fully utilized.

It seems, therefore, fitting to say a few words about the pioneers in this field. Frederick W. Taylor, M.D., the father of scientific management, is the oldest among them. He laid the foundations for modern methods engineering, when he, more than 50 years ago, as a foreman of a department of the Midvale Steel Company came to the following conclusions:

1. That production was the foundation for material prosperity.
2. That the workers by no means produced as much as they could.
3. That greatest production results when each worker is given a definite task, to be performed in a definite time and in a definite manner.
4. That a system of rewards was necessary for the accomplishment of the established task. Thus the wage incentive was born.

Taylor stressed also the importance of methods in the achievement of higher production. Many of those who applied Taylor's procedures, however, tended to neglect the factor of method. The reason for this was the spectacular results in production from the introduction of incentive systems, which permitted a worker to earn according to his own volume of production.

FRANK GILBRETH

It became the lifework of another scientific management pioneer to bring methods back into the picture. His name is Frank B. Gilbreth. He is not only well known to us all, professionals and laymen alike, through the book "Cheaper by the Dozen," but also through his wife, Dr. Lillian M. Gilbreth, who courageously carried on her husband's work after his untimely death. She is today one of the outstanding inspiring personalities in the field of modern management and has personally contributed to the successful start of the present Hospital Scientific Management Project at the Medical Center of the University of Pittsburgh.

Frank Gilbreth's and his wife's contributions are particularly important in the field of motion studies. They developed the micromotion study procedure, based on Gilbreth's 18 basic elements of motions, which in varying sequence and with varying repetition occur in all manual or physical work, from the simplest to the most complex. This contribution of the Gilbreths made it possible to break down an operation into definite parts which would later be rearranged according to the principles of Motion Economy. The pattern followed by the motions in a procedure is what we call the method. The principles of motion economy determine which is the best method to use.

For some years the pro's and con's of Taylor's and Gilbreth's work were discussed by their many followers. They finally split into two groups. One was the time-study group, and the other was the motion-study group and neither could see eye to eye with the other.

SAME GOALS

However, as both groups learned more about each other's work and found that they actually were striving for the same goals and only used different language, differences were reconciled. As a result, the best features of both approaches were combined into a single, universally applicable procedure. This I have already referred to as common sense systematically applied, namely Methods Engineering or Work Simplification.

At this point, perhaps your reaction is, "What has all this to do with hospital work? It might be all right for industries that actually produce material goods, but in hospitals we deal with much more intangible things such as the health problems of the human being. Our work is too irrational due to unforeseen complications in the afflictions of the human body and mind. Our work is too different."

Perhaps I should console myself, rather than you, with the fact that such a reaction and the seemingly irrefutable arguments related to it are no different from those given at first, even today, by many people in industry. They soon change their minds, however. Modern management technics have received their due acceptance by all progressive leaders of industry. Wherever they are applied, they give highly satisfactory results.

Hospitals are by no means an exception to the applicability of these technics. This has been readily recognized by some modern hospital managements, who have already done much to improve working conditions for personnel and services to the patient, who is the most important beneficiary of all our efforts.

So that we may start from the same

point or level of approach to the problem of methods improvement in hospitals, I wish to give you the definition of Methods Engineering:

> "Methods Engineering is the technic that subjects each operation of a given piece of work to close analysis in order to eliminate every unnecessary operation and in order to approach the quickest and best method of performing each necessary operation; it includes the *standardization of equipment, methods, and working conditions;* it trains the operator to follow the standard method. When all this has been done, and not before, it determines by accurate measurement the number of standard hours in which an operator working with standard performance can do the job; finally, it usually, although not necessarily, devises a plan for compensating labor which encourages the operator to attain or to surpass standard performance."

The key word in this definition is the word "analysis." The existing procedures must first be carefully analyzed before any attempt is made toward improvements. In other words, we must know all the facts, their relationship to each other, as well as the nature of these facts before we make any changes.

Consequently, our next question is, "How do we go about making this analysis of the facts? Where do we start, and what do we do with the findings?"

MAKE UP A CHART

Let us use a general hospital for an example. A good start is to make up a chart of its organizational structure, the departments, and services shown in their actual relation to each other indicating areas of responsibility and lines of authority. This is commonly called an Organization Chart. To the trained eye it will soon reveal any violations of organizational principles in the overall picture as easily as it may suggest apparent inadequacies within a department. We have thus the basic outline of the hospital showing its overall functions by departments, such as: Economic and clerical administration, medical service, surgical service, nursing service, supply and maintenance departments, etc.

One of these areas will undoubtedly have priority over the others as to the need for improvements in its operation. This need may range from floor plan layout to personnel supervision. Once the department or service to be studied has been established, we proceed to our next step, the analysis of facts about that department. This will in turn give us a clue as to what particular phase of the department's activities we should give our immediate attention.

This analysis can be made by direct observation of activities in the department in question, or we may take a motion picture of procedures.

The activities are then systematically arranged on a *Process Chart.* By doing this we get a complete picture of what goes on and, to a certain extent, just how things are done. In the second part of this discussion, Miss Prickett will demonstrate in full detail the use of such a process chart and explain what can be gained by its use.

It is usually possible to spot at once many weak points in a process or activity by analyzing a chart of this kind. Once again we determine which problem should receive our attention first, and then continue to break down the problem still further.

OPERATION ANALYSIS

This process is called Operation Analysis. Hospital Methods Analysis Sheet is a tool of analysis. Simply stated, we can say it is a guide to the systematic asking of pertinent questions about any task.

To make the sheet useful to persons in addition to the one who prepares it, it is important to carefully identify the study. Therefore, we begin by recording the date of the study, in what department it was made, the task we are studying, and finally who performed this task. We feel that the classification of the worker is more important than the name. One of the things we want to find out is how well qualified the worker is to do the task.

Now we come to the study proper.

As you can see, the sheet is divided in two columns. The left one is headed "Determine and Describe" and the right one "Details of Analysis." The left column lists all important considerations or steps of a task, while the right one suggests pointed questions to be asked in reference to these considerations and steps.

An operation analysis is made for the purpose of improving the method of doing the task. It might, therefore, seem that this point should be considered first. All of the other factors listed on the Analysis Sheet, however, influence the method directly or indi-

(Continued on next page)

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rectly. Until they have been studied and improved as much as possible, it is inadvisable to begin a too detailed analysis of the method. In actual practice, it is seldom possible to complete the analysis of one factor at a time and then leave it for good. Several of the factors are interdependent, and a change in one may cause a change in others. However, the list indicates in a general way the course along which the analysis should proceed.

Typically, a methods analysis involves the nine points that are listed on your sheet. These points concern:

1. Purpose
2. Relation to other tasks
3. Quality
4. Material
5. Material Handling
6. Work Station and Equipment
7. Common Improvements
8. Working Conditions
9. Method

It is important that the Operation Analysis be made systematically so that all points are considered in the order of their relative importance and so that no possibility for improvement will be overlooked. At the same time, it is not necessary, even though desirable, that the analysis be made complete to the last detail for it to bring about worth-while results. The act of filling in the sheet causes one to look at a job in its details. A task is seen to be a *series of simple problems* instead of a single complex problem. The solutions to these problems are found to be comparatively simple when considered individually. In other words, the analytical approach is encouraged, and guidance is given through each step of the study.

AN EXAMPLE

Let us take an example with which you are all quite familiar, and quickly go through the first few steps of a methods analysis. Let us consider the task of processing used rubber gloves.

Question 1: What is the purpose of this task?

The first answer that comes to mind is: "To wash, dry, inspect, powder, sort, package, and sterilize the gloves to make them ready for use again."

We could stop there and start considering how each of these steps could best be performed. If we do, we are not looking deeply enough into the purpose of the task. Let us then ask another question: "Why are all these steps of washing, drying, inspecting, etc, the rubber gloves taken?" The answer to this question is: "To give the hands of the doctor, the nurse, or other person a sterile cover in order to protect the patient."

Now is the time to ask: "Is the task necessary?" "Of course," you would say, "it is vitally important to protect the patient from infections that may arise from, for instance, the contact of a bare hand with an open wound." All right, *but*, is it necessary to process the rubber gloves after use? Why not throw them away and use new ones? That would eliminate all the steps in the processing of gloves except possibly that of sterilizing them. "Too expensive," you will say. Well, perhaps we shouldn't use gloves at all, then. Perhaps we should focus our attention on finding a better way of giving the hands a sterile cover rather than trying to improve a poor, wasteful, or costly method? Perhaps we can develop some type of solution that will give the hands a sterile cover, and when this cover is no longer necessary, it can simply be washed off. Then we have eliminated the entire procedure of glove processing, and that would be the best work simplification of all.

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This example demonstrates the probing kind of questioning that is necessary in operation analysis to make it most effective.

Again, remember, all of the factors which are considered during a methods analysis affect the method of performing the task. When all of the improvements uncovered during the analysis have been summarized and put into effect, the result is that the method has been improved to the extent that it can be improved by methods analysis alone.

We come now to the most detailed type of analysis of a procedure. It covers the study of the two dynamic elements of Motion and Time.

I have already referred to these elements in the brief review of Taylor's and Gilbreth's contributions to scientific management. Today we are fortunate to have at our disposal a much improved technic over the stop-watch or the exclusive use of therbligs (Gilbreth's name backwards, expressing his 18 basic elements). This is the more and more widely used "Methods-Time Measurement" technic. MTM, as it is commonly called, is best explained by its own definition, which says:

> "MTM is a procedure which analyzes any manual operation or method into the basic motions required to perform it and assigns to each motion a predetermined time standard which is determined by the nature of the motion and the conditions under which it is made."

APPLYING TECHNIC

By applying this technic we learn the facts about the ultimate physical components of the methods picture. From here on we can start to rearrange things for the purpose of arriving at a method which will give the best result, in a human as well as in a material sense, the best result with the least effort and expense.

Now someone might say, "Motions and method patterns cannot possibly be so important that it pays to go to these lengths and details in the studying of the possibilities for improvements in efficiency and economy in a hospital."

It pays indeed to be this methodical. Just think for a minute about your own work in making improvements in the activities under your supervision. You will find that you were most successful when you knew the facts. Then you were really able to simplify the work; get more done than before, and see happier faces around you. And what did you actually do? You eliminated unnecessary motions and impractical work patterns and perhaps improved the necessary motions. You did Work Simplification!

Motions and work patterns are ever present in everything we do; from plain walking to performing the most complicated task. It is important that we develop good methods of working so we conserve time and energy and thereby do a better job of caring for the patient.

I have briefly discussed with you the following tools of Methods Improvement:

1. Time Study
2. Motion Study
3. Process Charts
4. Operation Analysis
5. Methods Analysis
6. Methods-Time Measurement

These tools are of great value, particularly when combined with the key words in our earlier definition:

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- **Osteoarthritis of the Cervical Spine**
- **Narrowed Intervertebral Foramen**
- **Other Conditions in Which Cervical Traction is Indicated**

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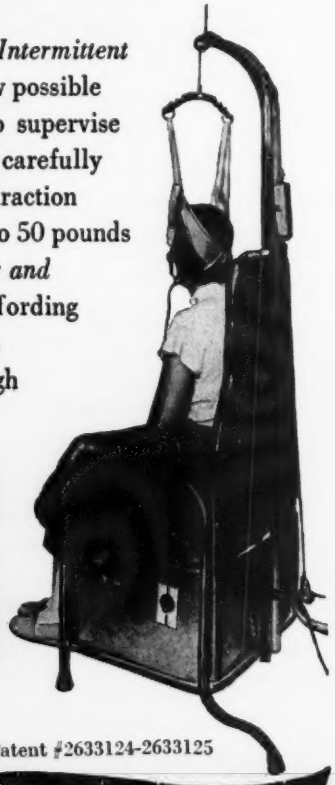

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WRITE FOR INFORMATION, CASE HISTORIES, LITERATURE

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Surgical & Orthopaedic Appliances
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TRADE TOPICS...

Irwin Neisler Men Win Cuban Trip

All expenses were paid on a "sky is the limit" basis when Irwin, Neisler & Co., Decatur, Ill., sent seven 1952 B.E.S.T. Contest grand prize winners, and wives, on a week-long Cuban holiday. Leaving their territories for the trip were: Mr. and Mrs. Gilbert E. Arbuckle, North Hollywood, Cal., Mr. and Mrs. Robert Chvatal, Bedford, O., Mr. and Mrs. Seymour L. Davidson, Miami, Mr. and Mrs. Burke DeLong, Fort Wayne, Ind., Mr. and Mrs. George Goodall, Belleville, Ill., Mr. and Mrs. Thomas A. Terveer, Beloit, O., and Mr. and Mrs. Marvin R. Weiss, Brooklyn.

The B.E.S.T. (Building Extra Sales Together) Contest, part of Irwin-Neisler's 1952 over-all sales program, was open only to sales representatives of the company. While the Cuban holidays were company-wide grand prizes, six divisional first prizes and 12 divisional second prizes were also awarded on a cash basis. Runners-up received various merchandise prizes, corresponding to their final contest standing.

M & R Award to Drs. Block and Davis

The M & R Awards for the two most significant articles to appear in the journal GP during 1952 went to Dr. E. A. Davis, Charleston, W. Va. for his paper "The Art and Ethics of Medicine," and to Dr. Marvin Block, Buffalo, N. Y. for "Alcoholism, the Physician's Duty." Presentation of the awards was made in St. Louis, March 24 by Dr. W. J. Shaw, chairman of the M & R Award Committee of the American Academy of General Practice, during the Academy's fifth annual meeting.

Below: Pictured in the ceremony are, l. to r. Dave Cox, Director of M & R Laboratories, donors of the Awards, Dr. Davis, Dr. Hugh Hussey, editor of GP, Dr. Block, and Richard M. Ross, Vice-President and General Manager of M & R Laboratories.

Graham-Field Address Is Corrected

Graham-Field, manufacturers of ilesotomy-colostomy units, are located in Woodside, N. Y., and not in New York City as listed in their advertisement on page 36 of the April issue.

Schumacher Appointed by Carolina Cotton

Carolina Absorbent Cotton Co. announces appointment of George L. Schumacher as new sales representative in Chicago, northern Illinois, and the states of Wisconsin, Minnesota, and Iowa, for both Carolina Cotton and its subsidiary, Richmond Dental Cotton Co.

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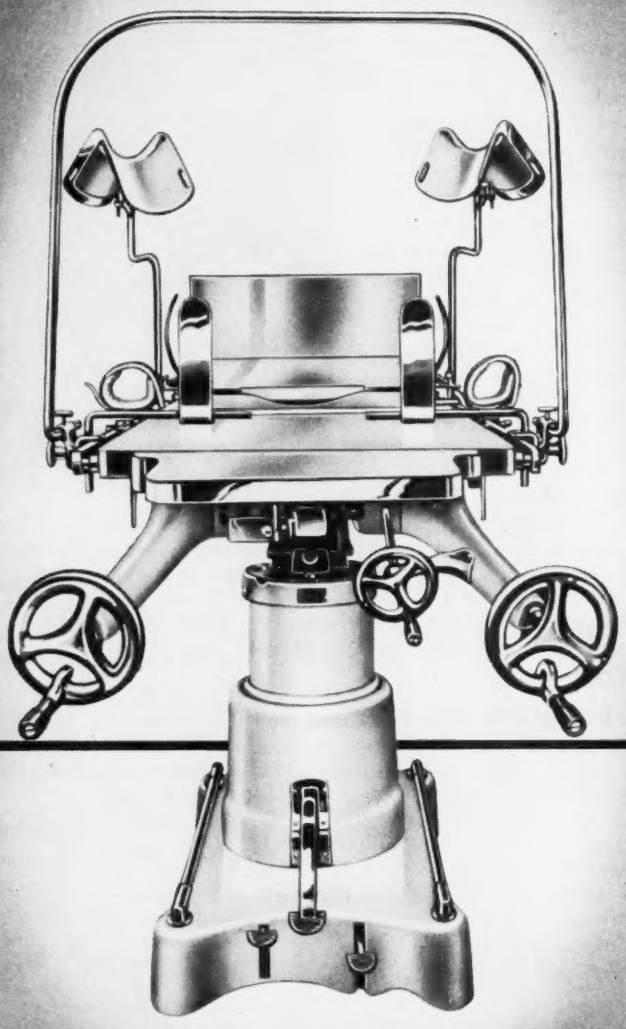

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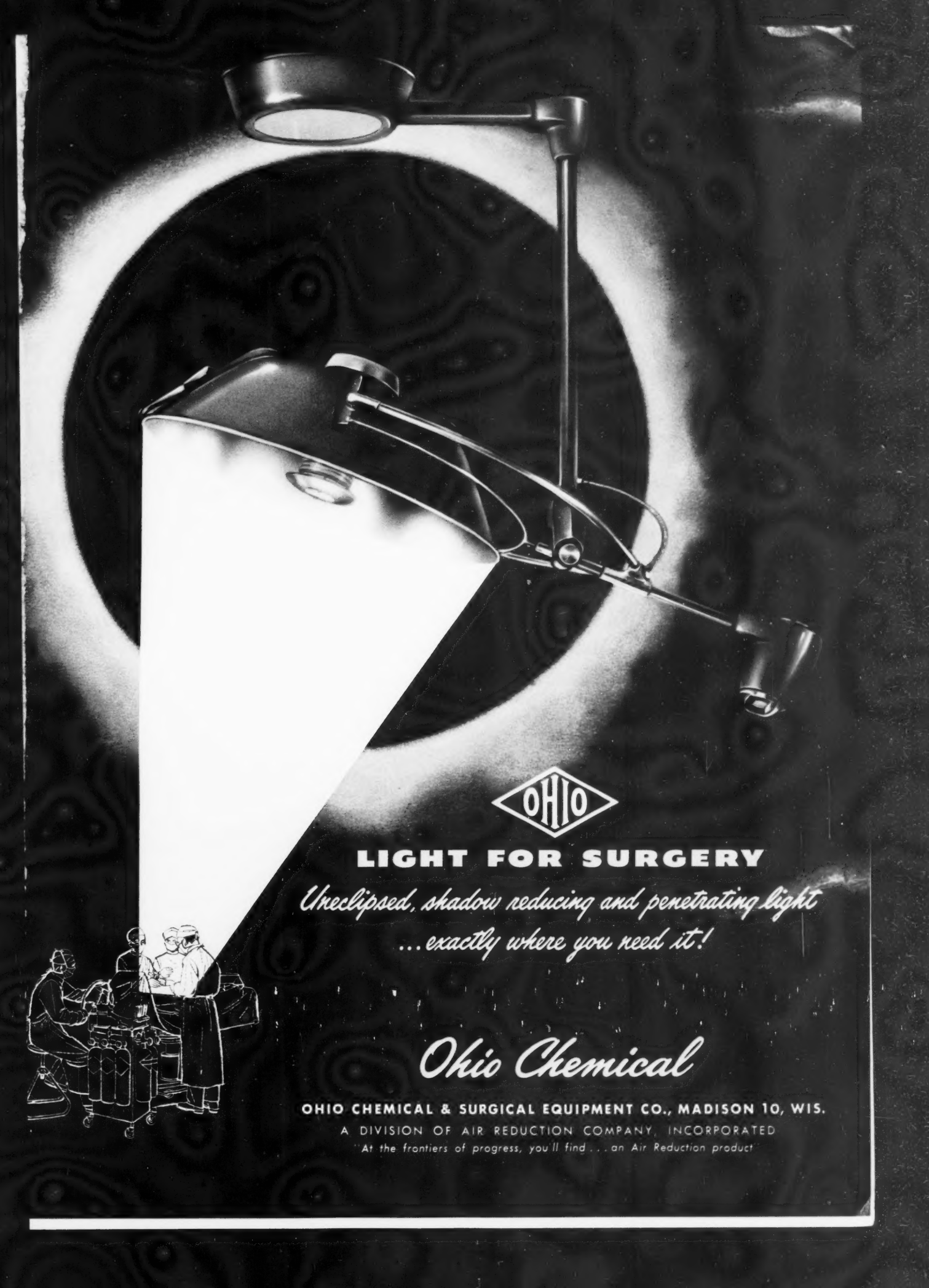
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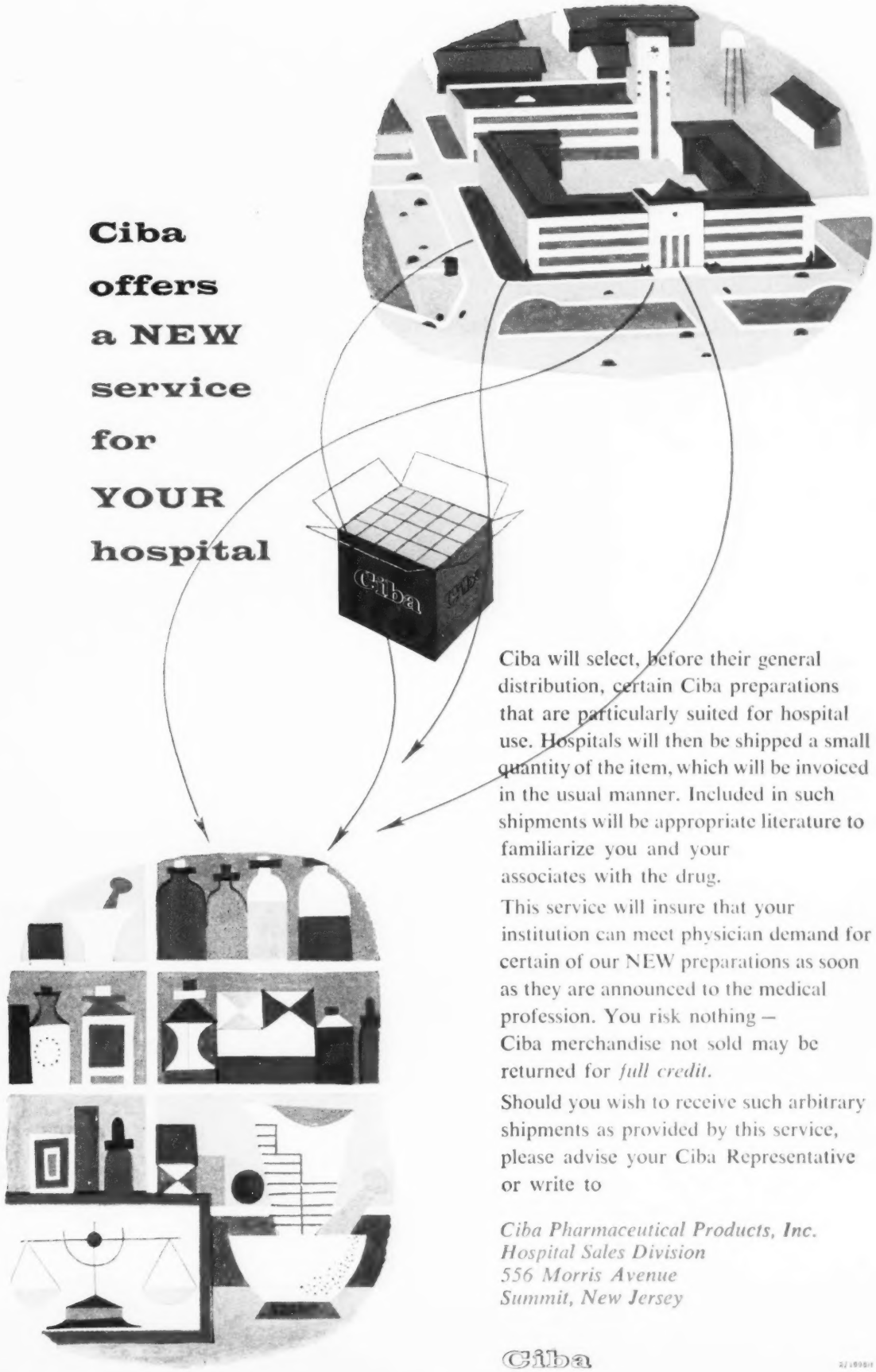

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